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SECRETARY OF THE AIR FORCE**

**AIR FORCE TACTICS, TECHNIQUES, AND  
PROCEDURES 3-42.6**



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***Tactical Doctrine***  
**USAF MEDICAL SUPPORT FOR  
SPECIAL OPERATIONS FORCES**

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**SUMMARY OF CHANGES:** This publication has been significantly revised and must be completely reviewed. This revision updates and clarifies information throughout the document including roles, responsibilities, and relationships at all levels. It updates United States Special Operations Command (USSOCOM) special operations forces (SOF) operational priorities and core tasks and revises the Air Force Special Operations Command (AFSOC) medical UTC narratives. It expands and clarifies medical doctrine and policy as applied to operational employment of AFSOC medical assets at home station and deployed. It expands the medical logistics, operational planning, and communications sections.

**PURPOSE:** The Air Force Tactics, Techniques, and Procedures (AFTTP) 3-42 series of publications is the primary reference for medical combat support capability. This document, AFTTP 3-42.6, provides an overview of special operations (SO) and the United States Air Force (USAF) medical tactics, techniques, and procedures (TTP) that support all special operations forces (SOF) and missions. It describes the organization, capabilities, planning, logistics, training, and operations of the Air Force Special Operations Command (AFSOC) Medical Forces. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 33-363, *Management of Records*, and disposed of in accordance with the Air Force Records Disposition Schedule (RDS) located at <https://www.my.af.mil/afirms/afirms/afirms/rims.cfm>. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF IMT 847, Recommendation for Change of Publication. Route AF IMT 847 through the appropriate chain of command and parent Major Command (MAJCOM).

**APPLICATION:** This publication applies to all Air Force military and civilian personnel including Air Reserve Components (ARC). This document is authoritative but not directive.

**SCOPE:** Special operations missions are conducted by specially organized, trained and equipped military forces to achieve military, political, economic or psychological objectives by unconventional means in hostile, denied, or politically sensitive areas. Whether operating from a main operating base (MOB), intermediate staging base (ISB), forward staging base (FSB), forward operating base (FOB), fire base (FB) or a combat outpost (COP), AFSOC medical assets

provide medical Expeditionary Combat Support (ECS) and casualty evacuation (CASEVAC) during operational missions for Air Force Special Operations Forces (AFSOF) and other SOF. AFSOC medical teams and designated line units support SOF by providing both mission operations support as well as SOF base operations support. These capabilities include initial, trauma stabilization, ongoing combat trauma care including surgical capability and CASEVAC, limited patient holding for post-operative or seriously ill patients awaiting transport, as well as more routine preventive and acute medical care for deployed SOF personnel.

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## Chapter 1

### SOF MISSION, OPERATIONAL PRIORITIES AND CORE TASKS

**1.1. Mission.** USSOCOM's mission is to provide fully capable and enabled special operations forces (SOF) to defend the Nation's interests in an environment characterized by irregular warfare.

#### 1.2. USSOCOM Priorities.

- Deter, Disrupt & Defeat Terrorist Threats
- Develop & Support Our People & Families
- Sustain & Modernize the Force

#### 1.3. SOF TRUTHS

- Humans Are More Important Than Hardware
- SOF Cannot Be Mass Produced
- Competent SOF Cannot Be Created After Emergencies Occur
- Quality Is Better Than Quantity
- Most Special Operations Require non-SOF Assistance

**1.4. SOF Core Activities.** America's special operations forces (SOF) are organized, equipped and trained, and then deployed by USSOCOM to meet the high demands of Geographic Combatant Commanders (GCCs) around the world. USSOCOM has the central role in planning and executing the worldwide campaign against terrorism. In both its supported and supporting roles, the command will successfully execute the mission as assigned and directed by the Secretary of Defense (SecDef). Additionally, Title 10 U.S. Code states that USSOCOM is to "prepare special operational forces to carry out assigned missions." Preparation covers areas such as: developing strategy, doctrine, and tactics; training assigned forces; conducting special courses; validating and prioritizing requirements; ensuring interoperability; monitoring promotions, retention and assignments; developing and acquiring special equipment. These responsibilities drive the command's eleven core tasks that stretch across the spectrum of peace and war. Forces provided to the theater commanders must be highly capable and relevant to the needed tasks.

**1.4.1. Direct Action:** Short-duration strikes and other small-scale offensive actions taken to seize, destroy, capture or recover in denied areas.

**1.4.2. Special Reconnaissance (SR):** Acquiring information concerning the capabilities, intentions and activities of an enemy.

**1.4.3. Unconventional Warfare (UW):** Operations conducted by, through and with surrogate forces that are organized, trained, equipped, supported and directed by external forces.

**1.4.4. Foreign Internal Defense (FID):** Providing training and other assistance to foreign governments and their militaries to enable the foreign government to provide for its country's

national security.

**1.4.5. Civil Affairs (CA) Operations:** Activities that establish, maintain or influence relations between U.S. forces and foreign civil authorities and civilian populations to facilitate U.S. military operations.

**1.4.6. Counterterrorism:** Measures taken to prevent, deter and respond to terrorism.

**1.4.7. Information Operations (IO):** Operations that provide truthful information to foreign audiences that influence behavior in support of (ISO) U.S. military operations. Operations designed to achieve information superiority by adversely affecting enemy information and systems while protecting U.S. information and systems.

**1.4.8. Counterproliferation of Weapons of Mass Destruction (WMD):** Actions taken to locate, seize, destroy or capture, recover and render such weapons safe.

**1.4.9. Security Force Assistance:** Unified action by joint, interagency, intergovernmental and multinational community to sustain and assist host nation (HN) or regional security forces in support of a legitimate authority.

**1.4.10. Counterinsurgency (COIN) Operations:** Those military, paramilitary, political, economic, psychological and civic actions taken by a government to defeat insurgency.

**1.4.11. Activities Specified by the President or SECDEF**

**1.5. AFSOC Mission.** The AFSOC mission is to present combat ready Air Force Special Operations Forces to conduct and support global special operations missions.

**1.5.1. AFSOC Core Missions.** AFSOC's 10 core missions define the activities for which AFSOC is organized, trained and equipped to accomplish during peacetime and hostilities. AFSOC delivers special operations power through 10 core missions to conduct and support global special operations missions anytime, anywhere.

**1.5.1.1. Agile Combat Support (ACS).** Effectively create, prepare, deploy, employ, sustain, and protect Air Force Special Operations Command Airmen, assets, and capabilities across the range of military operations at our initiative, speed, and tempo. *ACS: the foundational and cross cutting core mission for all other AFSOC core missions.*

**1.5.1.2. Aviation Foreign Internal Defense (AvFID).** AvFID operations directly support US security and foreign policy, providing lead airpower elements that shape the environment by working with partner nations (PN) to enable them to employ, sustain, and integrate their own aviation to support their own internal security, stability, and economic development. AvFID: *Assess, Train, Advise, and Assist.*

**1.5.1.3. Battlefield Air Operations (BAO).** A unique set of combat proven capabilities (Combat Control, Pararescue, Combat Weather, and Tactical Air Control Party) provided by regular and Air Force Reserve Component SOF Battle Field Airmen who integrate, synchronize,

and control air space assets (manned and unmanned) to achieve, tactical, operational, and strategic objectives. BAO: *a unique mission that touches each and every AFSOC mission.*

**1.5.1.4. Command and Control (C2).** C2 is the exercise of authority and direction by a properly designated commander over assigned and attached forces in the accomplishment of the mission. C2: *light, lean, agile, and relevant.*

**1.5.1.5. Information Operations (IO).** The integrated employment of the capabilities of influence operations, electronic warfare operations, and network warfare operations, in concert with specified integrated control enablers, to influence, disrupt, corrupt, or usurp adversarial human and automated decision making while protecting our own. IO: *affecting the perceptions and behaviors of the adversary.*

**1.5.1.6. Intelligence, Surveillance and Reconnaissance (ISR).** Synchronized and integrate the planning and operation of sensors and assets for tasking, collecting, processing, exploitation, and dissemination. ISR: *for the creation of predictive battle space awareness.*

**1.5.1.7. Precision Aerospace Fires.** An integrated capability to find, fix, tract, target, engage, and assess targets using a single weapons systems or a combination of systems. Precision Aerospace Fires: *deploy globally, strike precisely. (AFSOC retains the term "aerospace" in describing its core missions and so it is retained here. This term has been generally superseded by "airpower" in doctrinal usage. Reference AFDD 3-05)*

**1.5.1.8. Military Information Support Operations (MISO).** Planned operations to convey selected information and indicators to foreign audiences to influence their emotions, motives, objectives, reasoning, and ultimately the behavior of foreign governments, organizations, groups, and individuals. MISO: *Targeting the mind of the adversary.*

**1.5.1.9. Specialized Air Mobility. (SAM).** The conduct of rapid global infiltration, infiltration, and resupply of personnel, equipment, and material using specialized systems and tactics. SAM: *the ability to employ SOF at a moment's notice.*

**1.5.1.10. Specialized Refueling (SREF).** The conduct of rapid, global refueling using specialized systems and tactics. SREF: *Increasing the range, payload, loiter time, flexibility and versatility.*

**1.6. SOF Operational Environment and Medical Support Implications.** Characteristic mission requirements of AFSOC mission profiles make it necessary to modify conventional medical planning methods for providing medical support. Special operations are high risk/high gain operations; are usually conducted on short notice; are under significant operations security (OPSEC) considerations; are generally in enemy held, denied, or sensitive territory, and are conducted by specially organized, trained, and equipped forces in pursuit of national objectives.

**1.7. AFSOC Medical Mission Statement.** Deploy with and in support of (ISO) Special Operations Forces in order to (IOT) deliver SOF combat medical support and to modernize and advance SOF medical capabilities, medical technologies IOT maximize war-fighter performance. Provide high quality, state-of the-art prevention-based health care for AFSOC members, families and beneficiaries.

**1.7.1. AFSOC Medical Capabilities.** AFSOC medics provide a comprehensive medical platform for SOF personnel across the health care continuum--prevention through intervention and rehabilitation. SOF medics ensure deployable AFSOC forces via the employment of AFSOC medical UTCs. AFSOC medics deploy with SOF IOT provide preventive healthcare, routine healthcare, urgent/emergent point-of-injury trauma care, forward resuscitative/stabilization surgery, intensive care, CASEVAC and critical care casualty evacuation. Additionally, SOF medics provide medical support for humanitarian operations, noncombatant evacuation operations (NEO), civil affairs (CA) missions, irregular warfare (IW), unconventional warfare (UW) missions, foreign internal defense (FID) missions, medical stability operations, healthcare capacity building and health care infrastructure development capabilities ISO COIN operations, stability/security operations and medical support for other unique USSOCOM missions/taskings.

**1.7.2. Other Taskings.** AFSOF forces may be tasked to support operations which have a greater focus on humanitarian assistance (HA) and civil affairs. AFSOC medical forces will provide general preventive care and public health expertise to operational commanders without compromise to the primary mission of force health protection and deployed care.

**1.7.3. The Challenge of AFSOC Medicine.** The Challenge of AFSOC Medicine is to *provide the highest quality healthcare/health service support for AFSOC and joint special operations forces, frequently without the benefit of traditional pillars of health services support and often without the benefit of fully developed traditional echelons of care in austere, forward areas with significantly high medical and operational threat/risk. AFSOC operational medics are trained and equipped for permissive, uncertain and hostile operating environments.*

**1.7.4. Medical Threat.** The medical threat to AFSOC forces includes battle injuries from conventional as well as unconventional weapons including directed energy weapons, chemical, biological and nuclear or radiological weapons. Historically, disease and non-battle injuries (DNBI) have had a major impact on deployed military forces. The combination of austere operating environments and the small number of forces can allow any incidence of DNBI to have disastrous effects on SOF forces if not prevented. Various AFSOC forces may succumb to DNBI very rapidly because of extreme operating environments which include mission stresses, fatigue, task saturation, loss of situational awareness, psychological stress or from environmental factors (like heat, cold, altitude, and night/darkness). Diseases from water, food or vector borne sources as well as communicable diseases also remain great threats to the operational forces. The AFSOC medic must understand and plan for the above medical constraints while also being aware of the unique requirements of SOF aviators, airborne, diving, and ground combatants.

**1.7.5. Operational Environment.** AFSOC medical forces are selected from highly motivated personnel. These individuals are then extremely well trained and equipped. AFSOC medical forces will remain highly mobile, scalable, and flexible. They interface directly with sister service SOF and conventional medical teams and assets and must have an understanding of the roles and requirements within the other services. AFSOC medical forces should expect to perform their roles at night, during low-light, or blackout conditions using night vision devices and, at times, while experiencing circadian disruption. An additional and increasingly more frequent operational environment is one requiring interface with a HN health care system.



Ultimately, AFSOC medical forces must be focused on sustainment of the mission performance of SOF personnel and accomplishment of the mission.

**1.7.6. AFSOC Command Surgeon.** The AFSOC Surgeon (SG) is committed to providing the Commander, United States Special Operations Command (COMUSSOCOM) a robust medical capability. In turn, USSOCOM and AFSOC operational commanders encourage development of state-of-the-art equipment/supplies by providing funding. USSOCOM funds the development of medical solutions to problems identified by the Biomedical Initiatives Steering Committee (BISC). The BISC collects potential projects or problems from the Theater Special Operations Commands (TSOCs) and component surgeons for prioritization.

## Chapter 2

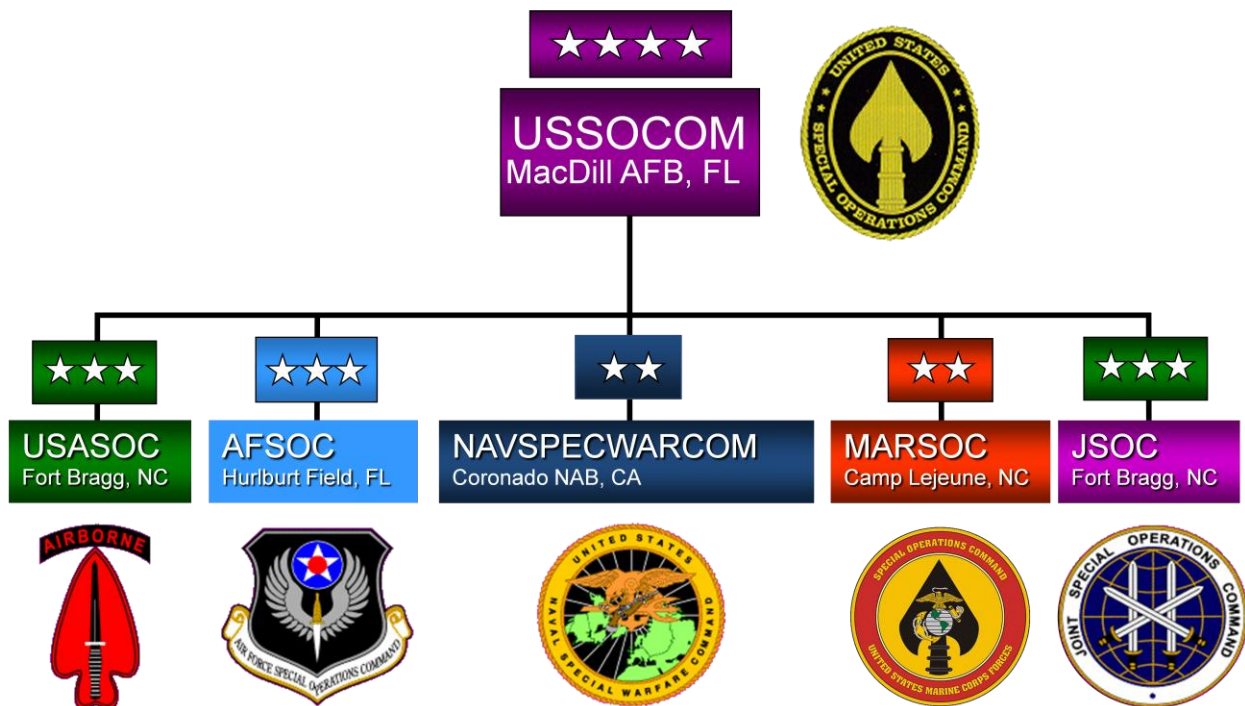
### ORGANIZATIONS, ROLES, AND RESPONSIBILITIES

#### 2.1. United States Special Operations Command (USSOCOM).

**2.1.1.** USSOCOM at MacDill AFB, Florida, is one of nine combatant commanders directly responsible to the President and Secretary of Defense. As a functional combatant command, USSOCOM has been given lead responsibility for waging war on terrorism. Its duties in connection with this responsibility include planning, directing, and executing special operations in the conduct of the war on terrorism. USSOCOM also provides special operations forces (SOF) to support the Geographic Combatant Commander's theater security cooperation plans. The designation of Special Operations as a Major Force Program makes USSOCOM unique among the nine combatant commands in that it has service-like responsibilities to organize, train, and equip its forces for special operations missions.

**2.1.2.** USSOCOM has five component commands and one sub-unified command: the US Army Special Operations Command, Fort Bragg, North Carolina; the Naval Special Warfare Command (NAVSPECWAR), Coronado, California; the Air Force Special Operations Command, Hurlburt Field, Florida; the Marine Corps Forces Special Operations Command, Camp Lejeune, North Carolina and the Joint Special Operations Command (JSOC), Fort Bragg, North Carolina. (See Figure 2-1)

Figure 2-1 USSOCOM Component Commands



**2.1.3. Theater Special Operations Commands (TSOCs).** Theater Special Operations Commands (TSOC) are sub-unified commands established within each geographic combatant command. The function of the TSOC is to ensure that SOF is fully integrated into the

Geographic Combatant Commander's collective security plans and contingency operations. The TSOC commander plans and conducts joint special operations, ensuring that SOF capabilities are matched to mission requirements while advising component commanders in theater on the proper employment of SOF. Additionally, TSOCs provide the core element for establishing a Joint Special Operations Task Force (JSOTF), a quick reaction command and control element that can respond immediately to regional emergencies. There are joint Service medical planners assigned to TSOCs. The seven TSOCs supporting geographic combatant commanders worldwide are: Special Operations Command Central (SOCCENT), Special Operations Command Europe (SOCEUR), Special Operations Command Pacific (SOCPAC), Special Operations Command South (SOC SOUTH), Special Operations Command Korea (SOCKOR), Special Operations Command Africa (SOCAFRICA), and Special Operations Command Joint Forces Command (SOCJFCOM).

## **2.2. Air Force Special Operations Command (AFSOC).**

**2.2.1. Headquarters.** AFSOC is headquartered at Hurlburt Field, Florida, and functions as both an Air Force major command (MAJCOM) and as the air component of USSOCOM. As a MAJCOM, AFSOC retains Title 10 responsibilities to organize, train, equip, administer, and maintain special operations forces for worldwide deployment and assignment to unified commands. As the air component of USSOCOM, AFSOC provides Air Force special operations forces (AFSOF) to accomplish assigned special operations mission activities. Also as the Air Force component, the AFSOC commander exercises command authority consistent with operational control (OPCON) over all Continental United States (CONUS)-based active and reserve AFSOF assets.

**2.2.2. AFSOC Surgeon.** The AFSOC/SG functions as a MAJCOM/SG and as the air component surgeon to USSOCOM. As a MAJCOM/SG, the AFSOC surgeon is responsible for establishing, coordinating, and sustaining a health care system for AFSOC personnel and for organizing, training, and equipping AFSOC medical forces for contingency medical support. As the air component surgeon to USSOCOM, the AFSOC/SG plans execution of all Air Force medical support for AFSOF and serves as the principal Air Force medical service advisor to USSOCOM.

**2.2.3. Organizational Structure.** AFSOC medical units and line units with medical responsibilities are currently organized into a Wing, Group, Squadron and flight configurations.

**2.2.3.1. Special Tactics.** AFSOC's 720th Special Tactics Group (STG) has six squadrons comprised of Pararescue, Special Operations Weather, and Combat Control, and AFSOC Tactical Air Control Party (TACP) personnel: the 23rd Special Tactics Squadron (STS) and 10th Combat Weather Squadron at Hurlburt Field, Florida, the 22nd STS at McChord AFB, Washington, the 24th STS and 21st STS at Pope AFB, North Carolina, the functional oversight of 320th STS at Kadena AB, Japan, and the 321st STS at RAF Mildenhall, United Kingdom.

**2.2.3.2. AFSOC Supported Units.** AFSOC provides leadership and oversight for the 1st Special Operations Wing (SOW) at Hurlburt Field, FL, the 27th SOW at Cannon AFB, NM, the 352nd Special Operations Group (SOG) at RAF Mildenhall, United Kingdom (UK), and the 353rd SOG at Kadena AB, Japan. The 352 and 353 SOGs are Direct Reporting Units (DRUs) to AFSOC/CC. AFSOC also has three other DRUs: the 18th Test Squadron, the 720th Special

Tactics Group (STG), and the Air Force Special Operations Training Center (AFSOTC), all located at Hurlburt Field, FL. Additionally, AFSOC has air reserve component (ARC) gained units: the 193rd SOW of the Pennsylvania Air National Guard (ANG) at Harrisburg Airport, Middletown PA; the 919th SOW of the Air Force Reserve Command (AFRC) at Duke Field, FL.

### **2.3. AFSOC Medical Preparedness and Force Protection.**

**2.3.1. Force Preparation.** The medical groups supporting AFSOC units, with the assistance of personnel in the Operations Support Medical flights (OSM), provide critical support to the AFSOC mission by preparing the force for deployed operations. SOF must be in a continual state of readiness to support minimal-notice tasking. Fitness and prompt attention to health problems are critical to assuring each member's readiness to perform in austere environments for prolonged periods. It is imperative for AFSOC units to participate in the fitness program to maintain a fit and ready force.

**2.3.2. Preventive Health Assessment (PHA).** The PHA is a critical factor in force protection. The PHA screens for disease risk factors warranting intervention, assesses disease control or management, updates immunizations, and assures good dental health. Certain predeployment surveillance measures are performed with each PHA to reduce activities immediately prior to any deployment. Some AFSOC personnel require more stringent assessments associated with specific career fields. These measures greatly expedite AFSOC member processing for deployment and unit commanders are assured of the fitness and health of members they deploy.

**2.3.3. Disease and Injury Prevention.** Prevention is a key competency of AFSOC medics at home station and while deployed. Experience has shown that preventable disease and non-battle injury (DNBI) can weaken or decimate force capability. DNBI is a particular risk to small force packages. Small teams are highly dependent on synergy gained from performance of individuals working as a team. At home station, prevention efforts concentrate on mitigation of health risk factors, elimination of unnecessary risks in training, and minimizing occupational injury. During deployed operations, AFSOC medics will provide mission commanders with assessments of operational risk and suggestions for diminishing risk within mission parameters. Prevention of disease during deployments pays particular dividends in force capability through reduction of risk from disease vectors, food-borne illness, water-borne illness, chemical, biological, and radiological related exposures, and endemic infectious disease.

**2.3.4. Human Performance Enhancement (HPE).** The AFSOC/SG is determined to fully exploit that specialized knowledge of the human weapon system and go one step further to determine, develop, or advocate new ways to enhance the performance capabilities of all AFSOC personnel. To that end, AFSOC/SG pursues HPE on two fronts: physiological enhancements and psychological enhancements.

**2.3.4.1. Physiological Enhancements.** Human limitations can be associated with physical endurance or mission duration, vision in dark environments, and altitude. There are also well known limitations to human performance secondary to exposure to enemy threats such as Directed Energy Weapons (DEW); ballistic weapons; and nuclear, biological, and chemical (NBC) weapons. To counter the adverse effects on performance each of these represents, the AFSOC/SG plans and advocates for countermeasures or other performance enhancement techniques or technologies. These include Laser Eye Protection (LEP) technologies, new

enhanced and advanced night vision systems, chemical/biological protection systems (masks, suits, detectors, and immunobiologics/vaccines), advanced body armor, fatigue countermeasures, biological/chemical countermeasures, and high altitude/decompression sickness risk mitigation.

**2.3.4.1.1. Human Performance Team (HPT).** This team serves as the AFSOC/SG representative for aerospace physiology in aviation human factors. The team conducts research to identify specialized life support equipment to enhance special operations effectiveness; they are members of an integrated aerospace medicine team working with local flight safety and flight medicine agencies; and they provide briefings with topics tailored to unit tasking and training programs. Additionally, they support regional helicopter and high altitude parachutists with specialized human performance training. These HPT personnel are assigned to the AFSOC SOF Aerospace Physiology Team UTC (FFQE5). This two person team with a corresponding equipment/supply (FFQEP) package provides oversight, management, and operational capabilities relating to human performance factors in deployed environments (i.e. High Altitude Airdrop Mission Support [HAAMS], hyperbaric medicine, mishap investigation, etc).

**2.3.4.2. Psychological Enhancements.** Aerospace and special operations psychology efforts employ primary, secondary, and tertiary prevention principles as a means of enhancing performance and reducing risk. AFSOC Operational Psychologists apply proven psychological principles to enhance individual and unit performance and security.

**2.3.4.2.1. First,** special duty attributes are determined and assessment/selection criteria are derived by applying objective processes and Squadron Medical Element (SME) expertise. Multi-perspective processes are developed to integrate, select, and position SOF personnel for mission security and success. This creates a psychological assessment and selection process that is based on operational SME expertise – AND – is defensible under investigative scrutiny.

**2.3.4.2.2. Second,** human performance enhancement training is provided in such areas as physiological self-controls, attention/energy management, stress optimization, critical incident recovery, and other psychological or interpersonal methods in covert and clandestine operations.

**2.3.4.2.3. Third,** all AFSOC Operational Psychologists maintain Joint Forces Command/Joint Personnel Recovery Agency (JFCOM/JPRA) certified capability to supervise psychological aspects of Survive, Evade, Resist, Escape (SERE) training and lead the SERE Psychology aspects of Personnel Recovery (PR) operations. They are also uniquely qualified to provide positively focused psychological recovery training for return to duty (RTD).

**2.3.4.2.4. Fourth,** Operational Psychologists are trained in provision of consultation to intelligence interviewing during deployment.

**2.3.4.2.5. Fifth,** Operational Psychologists support mishap investigations through provision of unique human behavioral individual and systems analysis.

**2.3.4.2.6. Sixth,** Operational Psychologists provide behavioral consultation support to commanders and decision teams.

**2.3.4.3.** The AFSOC SOF Psychologist is also assigned to the AFSOC SOF Psychologist UTC FFQE7. They serve as a member of the commander's staff, provides psychological support, consultation, and management for SERE repatriation resources and processes as specified JPRA. They are responsible for critical incident and RTD consultation related to mishaps and isolated or returned persons. They provide psychological consultation and intervention on human performance and resource optimization in SOF aviation and provide consultation to commanders. They consult to commanders on selection and placement of special duty personnel as required and advise information operations and psychological operations planners.

**2.4. AFSOC Medical System.** Special Operations Forces are required to operate in remote, austere, and or far-forward environments, which may not be adequately supported by conventional medical personnel. AFSOC Surgeon (SG) is tasked with providing a medical system that can provide full spectrum health care to the supported SOF personnel who may be deployed in these environments. The overall AFSOC medical system may be divided into the base medical groups, primarily focused on home station health care, and Operational Support Medical flights, focused on deployment medical support and Pararescue (PJ) assets that are focused on SOF operational team support.

**2.4.1. Home Station Health Support.** Home station health care supports the AFSOC mission through programs that promote force fitness and performance, preventive and acute care, and managed health care for active duty personnel and non-active duty beneficiaries. Medical service efficiency is optimized through sound business practices, effective utilization management/review, and cost-effective resourcing.

**2.4.1.1. Medical Groups.** AFSOC has two fixed health care facilities: the 1st Special Operations Medical Group (1 SOMDG), Hurlburt Field, Florida and the 27th Special Operations Medical Group (27 SOMDG), Cannon AFB, New Mexico. These units operate outpatient clinics that offer primary care, aerospace medicine, optometry, pediatrics, health promotion, bioenvironmental engineering, public health, physical therapy, behavioral health, women's health, and dental services. Their primary mission is to support the wellness and fitness of the host base beneficiary population by operating community-based ambulatory clinics.

**2.4.1.2. Operations Support Medical (OSM) Flights.** OSM flight personnel are UTC specific trained and equipped to support both the AFSOC flying mission as well as the medical support needs of deployed SOF units.

**2.4.1.2.1.** OSM personnel fall under the command and control (C2) of Line of the Air Force Commanders of special operations units. At home station, OSM personnel report to the Special Operations Support Squadron (SOSS) commander, but Special Operations Forces Medical Elements (SOFMEs) could also fall under the C2 of flying squadron commanders if assigned to that squadron as an SME. However, in either case, while deployed, OSM personnel report through Joint Special Operations Air Component (JSOAC) and/or JSOTF commanders to the Theater Special Operations Commander to the Component Commander (COCOM) Commander. AFSOC mission commanders maintain operational control of AFSOC medical personnel in order to support short notice and/or highly specialized missions and to ensure OSM personnel have the required training prior to being tasked to support such operations.

**2.4.1.2.2.** OSM flights have a combination of flight surgeons, medical technicians, public health and bioenvironmental engineering technicians, plans/operations officers, and organic medical logistics support. OSM flights vary depending on location but may have several complimentary medical components. OSMs may also be augmented by the local medical group for any personnel or capability shortfalls.

**2.4.1.2.3.** The primary role of OSM flights is to establish a comprehensive deployment medicine program to support routine care and provide a trauma response capability for deployed forces. OSM flights centrally manage the medical assets assigned to their respective groups. They provide oversight of personnel management, training requirements, war reserve materiel (WRM) assets, Status of Resources and Training System (SORTS), Medical Readiness Decision Support System (MRDSS), Air Expeditionary Force (AEF) Reporting Tool (ART), Defense Readiness Reporting System (DRRS), and other reporting requirements.

**2.4.1.2.4.** OSM flights focus on operational support medicine; i.e., deployed medical support, trauma care, and CASEVAC; home-station flight medicine for the flying community and their dependents; and the operational planning processes. OSMs also work closely with their local base medical group to support Preventive Health Assessment (PHA), aviation psychology, immunizations, deployment surveillance, and health promotion/prevention programs or processes.

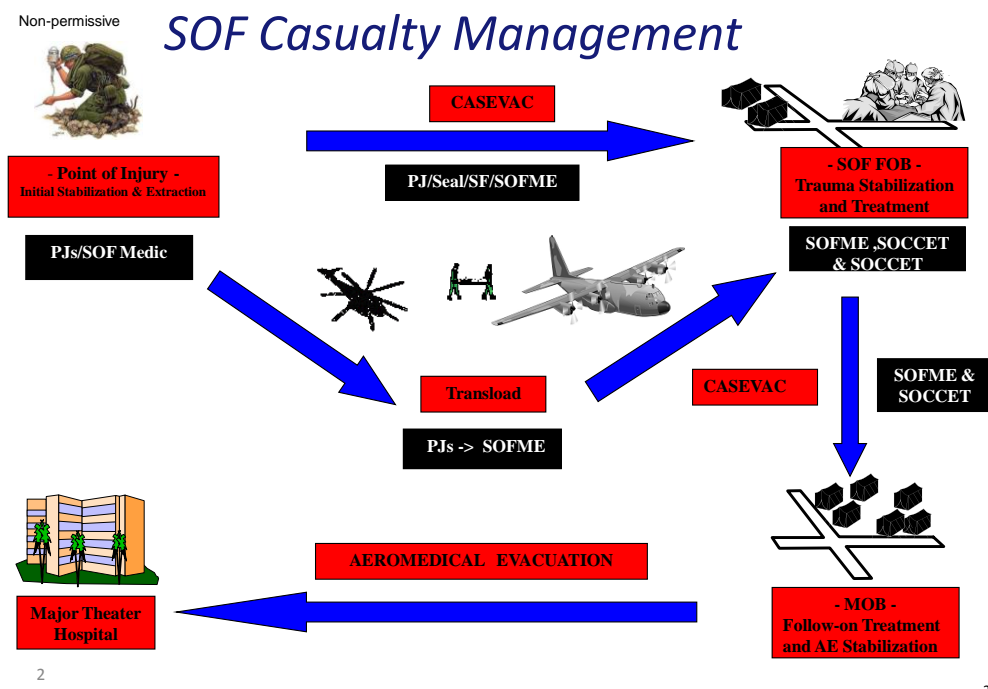
**2.4.1.2.5.** OSM medical personnel assigned to other AFSOC UTCs, such as the Special Operations Surgical Team (SOST) and Special Operations Critical Care Evacuation Team (SOCCET), train to support the AFSOC and SOF missions and maintain their clinical skills at the closest medical treatment facility (MTF) having that specialty service.

**2.4.1.3. Special Tactics Group (STG) Surgeon Roles and Responsibilities.** The STG/SG coordinates medical training and oversees appropriate medical equipment for medics and pararescuemen assigned to STG. The STG Surgeon must plan medical support for special tactics missions, participate in selection of special tactics candidates, and serve as the AFSOC Surgeon's consultant for medical issues specific to special tactics. The STG/SG will work with the AFSOC/SG and/or OSM flight commander/medical plans officer to ensure that roles and responsibilities of STG personnel and OSM personnel are well understood and that training is undertaken to enhance interoperability.

**2.4.1.4. Medical Group Interface with OSM Personnel.** OSM personnel are an important part of, and often serve as, a considerable portion of the medical capability at a particular base. Accordingly, close cooperation is required between OSM medical personnel and the host medical treatment facility (HMTF) to fully utilize valuable medical resources. This is particularly relevant to force preparation as well as the need to ensure medical currency among the OSM physicians, Physician Assistants (PAs), Independent Duty Medical Technicians (IDMTs), SOST and SOCCET personnel. AFSOC medical personnel have unique missions and operational support requirements significantly beyond conventional SME or Mobile Field Surgical Team/Critical Care Air Transport (MFST/CCATT) doctrine.

**2.4.2. Deployed Medical Care.** Deployed SOF medical support provides a continuum of medical care from point of injury utilizing Pararescue support to entrance into the formal ground medical and regulated Air Evacuation (AE) system. The SOFME is the essential component of AFSOC medicine and is the cornerstone around which AFSOC UTCs are built. In joint operations, SOFME and SOCCETs provide CASEVAC capability utilizing SOF ground, fixed/ rotary/tilt wing platforms to support USSOCOM components. AFSOC medical capability includes essential base operating support medical care and Forward Resuscitative Surgery (FRS) with the SOST to all component SOF units deployed in support of special operations missions.

**Figure 2-2 SOF Casualty Management**



**2.4.3. SOF Medical Elements (FFQEK).** The SOFME is a three person UTC; AFSOC's primary deployable medical element and the core AFSOC field medical team. The SOFME normally consists of one flight surgeon and two Independent Duty Medical Technicians (IDMT)/SOF-trained enlisted medics. However, this UTC may be tailored to meet operational mission requirements and may include SOF-trained physician assistants (PAs) in place of an IDMT/SOF trained enlisted medic. (AFTTP 3-42.61)

**2.4.3.1. SOFME Capability.** SOFME personnel have extensive medical training focused on combat health service support, trauma care, aeromedical decision making, and bare-base preventive medicine support. The key capability that the SOFME provides is deployed aerospace medicine support for AFSOC aircrews and special duty personnel [Pararescue Jumpers/Specialists (PJs), Combat Control Team (CCT), Combat Weather Team (CWT)]. The SOFME provides medical expeditionary combat support (ECS) and CASEVAC for AFSOF and other SOF. Medical Expeditionary Combat Support (ECS) includes, but is not limited to;



preventive/occupational healthcare, routine healthcare, urgent/emergent point-of-injury trauma care, forward resuscitative/stabilization, aeromedical decision making, aircraft mishap investigation, CASEVAC of injured/ill personnel and medical support for humanitarian operations, non-combatant evacuation operation (NEO), Civil Affairs (CA) missions, UW missions, FID missions, healthcare engagement, healthcare capacity building and healthcare infrastructure development capabilities ISO COIN operations, stability/security operations and medical support for other unique USSOCOM missions/taskings. Additionally, SOFME personnel utilize all sources of medical intelligence in order to (IOT) develop medical threat assessments and advise SOF commanders on how to mitigate potential medical threats. Furthermore, SOFME personnel provide appropriate aeromedical dispositions for ill or injured aircrew/other special duty personnel. The SOFME is specifically trained and equipped to provide SOF mission support and to establish bare-base operations in austere, forward and/or sensitive locations.

**2.4.3.2.** When deployed in conjunction with AFSOC equipment UTCs, a SOFME is capable of providing medical support to a deployed AFSOC unit for up to 30 days without resupply. Additionally, the SOFME is capable of providing casualty holding and staging for up to 24 hours and forward CASEVAC support for SOF units via opportune SOF aircraft.

**2.4.3.3.** SOFME personnel receive extensive training.

2.4.3.3.1. SOFME Flight Surgeon minimum training is as follows: Advanced Cardiac Life Support (ACLS)/Advanced Trauma Life Support (ATLS); Trauma Skills training; Pre-Hospital Life Support (PHTLS); Global Medicine; CASEVAC Course; Field Skills training; SERE training; and all appropriate aircrew block training.

2.4.3.3.2. All AFSOC enlisted medics trained as IDMT's must meet the minimal training as follows: Emergency Medical Technician-Paramedics (EMT-P), ACLS, Pre-Hospital Life Support (PHTLS), aeromedical evacuation training and/or CASEVAC Course Field Skills training, SERE training and all appropriate aircrew block training.

2.4.3.3.3. SOFME personnel may also receive initial and/or sustainment trauma management training via a SOF-specific training track at Joint Special Operations Medical Training Center and/or the Center for Sustainment of Trauma and Readiness Skills (CSTARS). Personnel train to operate in all types of weather, day or night, including low light or blacked-out conditions. SOFME personnel also train to acquire specialized tactical skills that are appropriate for the tactical environment and the supported customer. Furthermore, SOFMEs are trained to perform their duties onboard a variety of platforms (rotary, fixed and tilt-wing aircraft, ground vehicles, and maritime assets). Thus, SOFME personnel are organized, trained and equipped to effectively operate within austere, low/medium/high-threat, dynamic environments.

**2.4.3.4.** AFSOC Medical WRM assemblages provide the SOFME with medical supplies and equipment required to support SOF combat operations. All AFSOC WRM assemblages are packed to an allowance standard (AS) that ensures interoperability among AFSOC units and interoperability with sister service SOF units. The SOFME individual medical kit is comprised of a medical ruck sack (carried by each SOFME member) and medical supplies to support ATLS level care for 2-3 severely injured casualties. The SOFME Rapid Response Deployment Kit (RRDK) provides medical supplies required to establish ISB/FSB/FOB/FB/COP medical support

for a deployed population at risk (PAR) of 200. The SOFME CASEVAC kit includes equipment/supplies necessary to evacuate injured/ill personnel.

**2.4.3.5.** The SOFME provides casualty and disease management during SOF operations to stabilize injured or ill patients while moving them to/towards definitive care. AFSOC deployed capabilities for management of disease and injury can be characterized by four phases: (1) Self Aid and Buddy Care (SABC); (2) initial response; (3) stabilization and treatment; (4) CASEVAC. The SOFME is responsible for phases 2 through 4. The four phases of SOF medical response may overlap and/or occur simultaneously, depending on the situation/scenario. If movement by air is immediately available and/or rendered urgent by the tactical situation and/or medical condition of the patient/casualty, stabilization/treatment may occur during CASEVAC.

**2.4.3.5.1. Rapid Response Deployment Kit (RRDK) (UTC FFQEM).** The RRDK package contains trauma, sick call, preventive medicine and emergency medical treatment resources for short term (not to exceed 30 days) tactical deployment of special operations forces to an austere location. When deployed in conjunction with SOFME personnel, this UTC is capable of providing basic outpatient and advanced trauma life support. For daily sick call and base operating support, the RRDK can support 200 personnel for 30 days without resupply. The RRDK is composed of four modules; Advanced Resuscitation Module, Trauma Module, Environmental Module, and Medical Module. Each module has a specific function. The Advanced Resuscitation Module is comprised of medical supplies and equipment to support advanced cardiac life support. The Trauma Module provides supplies and equipment for Advanced Trauma Life Support, both at the base level and during CASEVAC missions. The Environmental Module encompasses equipment and supplies utilized for conducting public health threat assessments at a deployed location. The Medical Module is packed with medical equipment and supplies to provide routine (clinical/sick-call) patient care.

**2.4.3.5.2. CASEVAC Kit (UTC FFQEN).** This UTC provides additional equipment for SOFMEs supporting extended base operations. The CASEVAC equipment module is designed to provide in-flight casualty treatment, sustainment and monitoring, as well as the ability to transport and store blood and blood products. The CASEVAC Kit adds a communication suite that enables the SOFME to transmit secure voice/data in support of casualty management and disease non-battle injury (DNBI) tracking. This kit complements the RRDK and supports CASEVAC of two critical patients per mission.

**2.4.3.5.3. SOF Air Transportable Treatment Unit (ATTU) (UTC FFQEL).** The SOF ATTU is a mobile medical treatment facility for establishing an environmentally controlled shelter that is complete with generators, environmental control unit, and tents. It may be deployed with the SOFME to provide shelter for primary care and emergency medical operations. Additionally, ATTU contains a laptop computer and other administrative supplies for a deployed SOFME. It provides temporary holding and staging shelter for aeromedical evacuation. SOFMEs supported with an ATTU can be self-sufficient for short periods, but requires Base Operating Support (BOS) for extended duration operations.

**2.4.3.6. SOF Medical Element Augmentation (UTC FFQE8).** SOF Medical Element Augmentation Team: This 4-man team consists of a Physician Assistant, Bioenvironmental

Engineering technician, Public Health technician, and a medical plans officer. SOF Medical Element Augmentation is designed to augment bare base operations that are serviced by a SOFME. The package enhances capability to perform food safety, field hygiene/sanitation, vector surveillance, communicable disease control tasks, medical logistics and operational planning. Additionally, it provides chemical, biological, radiological, nuclear, and environmental threat detection, limited patient decontamination capability, and long term industrial hygiene sustainability and environmental protection surveillance. It is important to note that this element is not staffed or equipped to perform overall base wide decontamination and close coordination with the deployed base commander must be maintained to prevent any misinterpretation of this specific capability. (AFTTP 3-42.61)

**2.4.3.6.1. SOF Medical Augmentation Equipment Package (UTC FFQEG).** This package provides enough equipment and supplies for limited bare base support for force protection health surveillance and decontamination activities.

**2.4.3.6.2.** The personnel assigned to the SOF Medical Element Augmentation need to be proficient in their individual Air Force Specialty Code (AFSC) and a well trained member of a limited patient decontamination team.

**2.4.3.7. Special Operations Surgical Team (SOST UTC FFQE3).** The five-person SOST is composed of a General Surgeon (45S3), an Orthopedic Surgeon (45B3), an Emergency Services Physician (44E3A), Advanced Practice Nurse – Certified Nurse Anesthetist (046Y3M), substitutable with an Anesthesiologist (45A3), and a Surgical Services Craftsman (4N171). The SOST comprises the core of AFSOC's advanced surgical capability. The five-member team and accompanying supply and equipment increments (UTCs FFQEF/E/S) can be airlifted in any aircraft. Ground transportation can be accomplished in a single High Mobility Multi-Wheeled Vehicle (HMMWV), field ambulance or larger size vehicle. The equipment package to support the SOST is organized such that it can be palletized as personal or professional gear. The majority of supplies and equipment are maintained in five man-portable field packs. The ability to attain initial operating capability within 15 minutes is dependent upon the back packs being available to the team members immediately upon arrival at the site. The team requires shelter and potable water to be operational. Once operational, it can be self sufficient for 48 hours and then requires normal base operating support. The planning goal for medical support to SOF should be to insure surgical capability as close to the golden hour as physically possible. SOSTs are trained in SOF operating environments and may function in a stand-alone mode for short periods of time. They will typically be deployed as surgical augmentation with the SOFMEs who provide the shelter, power, water, and other operational requirements. (AFTTP 3-42.65)

**2.4.3.7.1. SOST Capability.** The SOST is designed to be a lightweight, rapidly deployable far-forward surgical team that can provide advanced emergency medical and surgical care to combat and other casualties within 15 minutes from the time of infiltration to a usable shelter of opportunity. The SOST can provide damage control surgical stabilization and emergency medical care to injured or critically ill patients in any environment. SOST can perform up to 10 damage control surgeries utilizing the primary equipment package. Once on location, the team equipment and personnel can be tailored to provide immediate on-scene trauma response and far-forward surgical resuscitation utilizing shelters of opportunity or full surgical stabilization from a forward operating base depending on the needs of the mission. Laboratory data is restricted to a hand held clinical lab analyzer. Radiographic imaging is

limited to abdominal sonography. Medications are limited to those essential for emergency resuscitative care, resuscitative surgery and immediate post-operative critical care. The SOST can operate independently for short periods of time in a limited number of scenarios (e.g., disaster response) but their full capabilities are realized when co-located with SOCCET. Capability is limited to the primary deployment package unless medical resupply is readily available. As such, SOST capability can be expanded modularly for larger scale operations of longer duration.

**2.4.3.8. SOST Equipment Package.** The SOST equipment package is modular and composed of three complementary allowance standards. The first increment can stand alone for initial care but all three are required to provide patients with optimal medical care.

**2.4.3.8.1. SOST First Increment (UTC FFQEF).** This primary equipment package is contained in portable field packs and holds supplies for up to 10 resuscitative surgeries. Personnel will deploy with four portable packs. SOST personnel, equipment and supplies can be transported by a single HMMWV or UH-60 Blackhawk helicopter or larger vehicle/aircraft.

**2.4.3.8.2. SOST Second Increment (UTC FFQEE).** The second increment is designed to augment the first increment and includes the electronics package and part of the communications package.

**2.4.2.8.3. SOST Third Increment (UTC FFQES).** The third increment is one full pallet position of equipment and supplies and adds further augmentation and resupply to the first and second increments, significantly extends operational capability to more than twenty major surgeries until resupply is in place.

**2.4.3.9. Special Operations Critical Care Evacuation Team (SOCCET UTC FFQE4).** The three-person SOCCET UTC is composed of an Emergency Services Physician (44E3A), substitutable with a Critical Care Physician (44Y3), Anesthesiologist (45A3), a Critical Care/Emergency Department Nurse (46N3E/J) and a Cardiopulmonary Craftsman (4H071). The SOCCET comprises the core of AFSOC's advanced critical care evacuation and post operative capability. It provides the personnel for critical care med management to casualties transiting the SOF casualty evacuation system. It provides continued trauma and post-operative casualty management aboard SOF aircraft and other opportune transportation platforms. It deploys with UTCs FFQEB/C/D, special operations critical care evacuation equipment sets. The SOCCET with equipment/supply packages, provides critical care medical management to AFSOC casualties both in theater and while transiting the non-regulated CASEVAC system. The team can provide continued trauma and post-operative medical support aboard SOF ground, aircraft, and other opportune evacuation platforms. The SOCCET is a highly flexible unit designed to operate in conjunction with the SOFME and/or SOST, or other SOF or conventional joint service medical elements, or in some limited or specific situations, they can be tasked to operate independently. This UTC is designed to operate in conjunction with a SOFME but can be tasked independently to support an evacuation mission on SOF aircraft. (AFTTP 3-42.65)

**2.4.3.9.1. SOCCET Capability.** The SOCCET provides critical care medical management to SOF casualties both in theater and while transiting the non-regulated CASEVAC. Each team can provide continued trauma and post-operative medical support aboard any SOF air,

sea, or ground evacuation platform. Their capabilities include initial resuscitation, (including advanced airway management, circulatory support and ATLS), pre-surgical stabilization and transport of combat casualties in addition to postoperative management and transport of critical combat casualties and other critically ill patients. Each team can provide critical care management to two critical patients per sortie with a holding capability of 12 to 24 hours. As with SOST, the SOCCET capability can be expanded modularly for larger scale operations of longer duration.

**2.4.2.10. SOCCET Equipment Package.** The SOCCET equipment package is modular and composed of three separate allowance standards.

**2.4.3.10.1. SOCCET First Increment (UTC FFQEB).** This increment is contained in portable field packs, is designed to be the minimal response package upon notification of a mission. It contains the required equipment to monitor and mechanically ventilate one patient as well as provide combat care and stabilization for three casualties. A total of four patients, two intubated and two patients requiring minimal monitoring, can be transported utilizing this equipment package.

**2.4.3.10.2. SOCCET Second Increment (UTC FFQEC).** Deploying the second increment provides the capability to care for three patients for 48 hours. The second increment duplicates the first increment and adds two gear cases that contain the Intensive Care Unit (ICU) patient holding supplies. This allowance standard enables the SOCCET to provide initial trauma response, post-operative stabilization, minimal ICU holding (48 hours or less) and patient transport. Ideally, no more than three critical ventilated patients should be sustained and transported using this allowance standard. Three patients requiring minimal monitoring can also be maintained and transported.

**2.4.3.10.3. SOCCET Third Increment (UTC FFQED).** Adding the third increment provides equipment for power generation, communication, battery charging, and blood holding capability for 72 hrs of sustained intensive care. This UTC can be utilized by both SOST and SOCCET.

**2.4.3.11. SOST/SOCCET Synergy.** SOST and SOCCET teams can deploy independently of one another but optimal resource utilization involves the SOST and SOCCET deploying and working together in a synergistic fashion. When the SOST and SOCCET are deployed in conjunction with the SOFME, medical capability at a staging base is greatly enhanced and gives AFSOC the capability of providing a robust medical presence. These UTCs are designed to provide a specific capability and should not be fragmented or their personnel deployed independently to meet non-standard UTC missions.

**2.4.3.12. Additional Support Requirements.** When SOST and SOCCET deploy together or with other AFSOC medical UTCs, and/or expect to remain in theater for an extended time, a Medical Plans and Operations Officer should deploy with the teams to support the operational planning and logistical requirements. When these teams operate at a FOB for an extended period, it would also be advantageous to add to the tasking a SOFME Augmentation Team, consisting of a Physician Assistant (42G3), Bioenvironmental Engineering Technician (4B071), Public Health Technician (4E071) and a Medical Planner (41A3).

**2.4.3.13. Operational capability of AFSOC SOST and SOCCET.** SOST and SOCCET provide the highest quality of care support in higher operational threat environments and where the traditional pillars of health service support are not available. Medically, they train to operate in all types of weather, day or night, including low light or blacked-out conditions.

Operationally, they train in specialized tactical skills that make them capable of interacting with SOF elements that they support rather than a liability. The SOST train to perform their duties at a variety of sites and the SOCCET are trained on a variety of platforms (rotary-, tilt-, and/or fixed-wing aircraft, ground vehicles and maritime assets). Thus, SOST and SOCCET can operate from austere environments, bare base or fixed base facilities in hazardous/high threat and dynamic environments.

**2.4.3.14. AFSOC SOF Aerospace Physiology Team (UTC FFQE5).** This two person team with a corresponding equipment/supply (FFQEP5) package provides oversight, management, and operational capabilities relating to human performance factors in deployed environments (i.e. High Altitude Airdrop Mission Support [HAAMS], hyperbaric medicine, mishap investigation, etc). (AFTTP 3-42.63)

**2.4.3.15. AFSOC SOF Psychologist (UTC FFQE7).** This UTC provides a member to the commander's staff that provides psychological support, consultation, and management for SERE repatriation resources and processes as specified Joint Personnel Recovery Agency (JPRA). They are responsible for critical incident and RTD consultation related to MISHAPS and isolated or returned persons. They provide psychological consultation and intervention on human performance and resource optimization in SOF aviation. The psychologist also consults to commanders on selection and placement of special duty personnel as required and advises information operations and psychological operations planners. (AFTTP 3-42.62)

**2.4.3.16. SOF Medical Command Element (UTC FFQE1).** This UTC provides a command medical staff element for deployed AFSOF/SOF headquarters command for contingency operations. The 3 passengers (PAX) include Aerospace Medicine Physician (48GX), Health Services Administrator (41A3), and Aerospace Medical Service Craftsman (4N071). It provides core medical command staff advisors for deployed SOF commander and serves as AFSOC component medical planners, medical staff, and medical advisors to deployed AFSOC/SOF commander. It provides medical oversight of deployed medical assets, medical programs and medical force health protection measures. They provide medical input to required briefings and reports and serves as liaison with other medical elements and HN medical agencies. If it deploys prior to main force, it can provide limited base medical support for 100 personnel for 7 days. Can deploy with UTCs FFQEM, FFQEL, and FFQEN.

**2.4.3.17. SOF Flight Medical Augmentation (UTC FFQE9).** This UTC provides additional flight medical support personnel to an operational AFSOC squadron or other special operations unit. Deploys in conjunction with UTCs FFQEK and FFQEM, and is capable of providing primary care and aerospace medicine to a deployed AFSOC unit for durations up to 30 days without resupply. The SOF specific UTC will extend the base support capability of UTC FFQEK (SOFME) at the deployed location. 2 PAX – Aerospace Medicine Physician (48G3), Aerospace Medical Service Craftsman-7-Level (4N071).

**2.4.3.18. SOF Irregular Warfare/Medical Stability Operations (IW/MSO) Team (UTC FFQE2).** This UTC provides medical personnel to execute missions in support of (ISO)

IW/MSO program. It is primarily intended to support geographic combatant commanders' (GCC) theater security cooperation goals and objectives by building partnership capacity in health and medical services and infrastructure. It may also be used for missions and operations with USAF Combat Aviation Advisor (CAA) squadron by providing additional medical capabilities. It is primarily intended to deploy and collocate with US SOF forces. It may also deploy to work directly with local populations through the PN ministries of defense or health or the US embassy country team. This UTC can be deployed in total or increments to meet operational mission requirements.

**2.4.3.19. SOF IW/MSO Augmentation (UTC FFQET).** This UTC provides additional medical personnel to execute missions in support of IW/MSO program. It is designed to provide additional medical personnel to FFQE2 UTC. It can collocate with partner-nation forces and other Department of Defense (DoD) forces to support theater combatant commanders during missions and operations. UTC can be deployed in total or increments to meet operational mission requirements.

**2.4.3.20. SOF Mental Health Flex Team (FFQEY).** This UTC provides uniquely trained human behavior experts for consultation to unit members and leadership. It serves as a mobile and proactive performance enhancement and mental health support/consultation asset implementing capability across a wide range of afsoc units. UTC members integrate with multiple units developing a broad force perspective, and credibility and accessibility with deployed personnel to function as a force multiplier. Members work primarily in operational units, developing an integral role in unit missions and challenges. They are available to intervene in the few instances when significant medico-psychological readiness impairments arise. They can deploy independently or with other AFSOC medical and/or operations UTC.

**2.4.4. AFSOC Pararescue Forces.** Pararescue Specialists (PJs) within AFSOC units are line combatants with additional trauma management medical capabilities as well as advanced tactical equipment and skills. Because of their combat skills and training, they are the most appropriate resource to render trauma medical support in threat environments and increased risk scenarios. PJs are specifically trained as crew members and for combat surface operations either independently or in conjunction with other SOF Teams. It is critical that PJs and SOFMEs maintain interoperability in mission overlap areas, specifically, CASEVAC and en route medical care. PJs are capable of performing basic CASEVAC. However, the significantly higher level of medical care provided by SOFME CASEVAC must be considered during mission planning. Patients under the care of PJs will always be passed to SOFMEs or other higher levels of medical care as soon as possible. This ensures patients receive increasingly higher levels of medical care and facilitates keeping PJ assets available to execute the PJ-specific mission.

**2.5. Irregular Warfare/Medical Stability Operations (IW/MSO).** AFSOC/SG Irregular Warfare/Medical Stability Operations supports the overall Air Force and AFSOC IW program. IW is a strategy, not tactics and health care engagement is a tool. It is an area within shaping and stability operations that is essential to building the PN military and government capacities in medical and healthcare. The focus of IW missions and operations are on the local population. The objective is to gain the support of the population for the legitimate government by building capacity. Capacity building transfers knowledge and skills to individuals and institutions so they can acquire the long term ability to establish effective policies and deliver competent public service. By ensuring the population's security, the government can receive the population's

support and allegiance and deter the population from seeking out other groups (i.e. insurgents) who will assure their security. Human security includes physical security, as well as the population's basic health needs (nutrition, water, shelter, and medical). AFSOC will continue to expand their current medical capabilities and develop new capabilities as needed to allow AFSOC to perform the IW/ and MSO missions. AFSOC/SG has established two personnel UTCs (FFQE2 and FFQET) and one equipment UTC (FFQEW) specifically for IW/MSO missions. AFSOC medical groups are tasked to support the FFQE2 and FFQET UTCs and the Air Reserve Component medical units (193rd Medical Group/ANG and 919th Medical Squadron/AFRC) are tasked to support the FFQE2. The FFQEW IW/MSO equipment sets are being built and will be assigned to the active duty medical groups at Hurlburt Field, FL and Cannon AFB, NM.

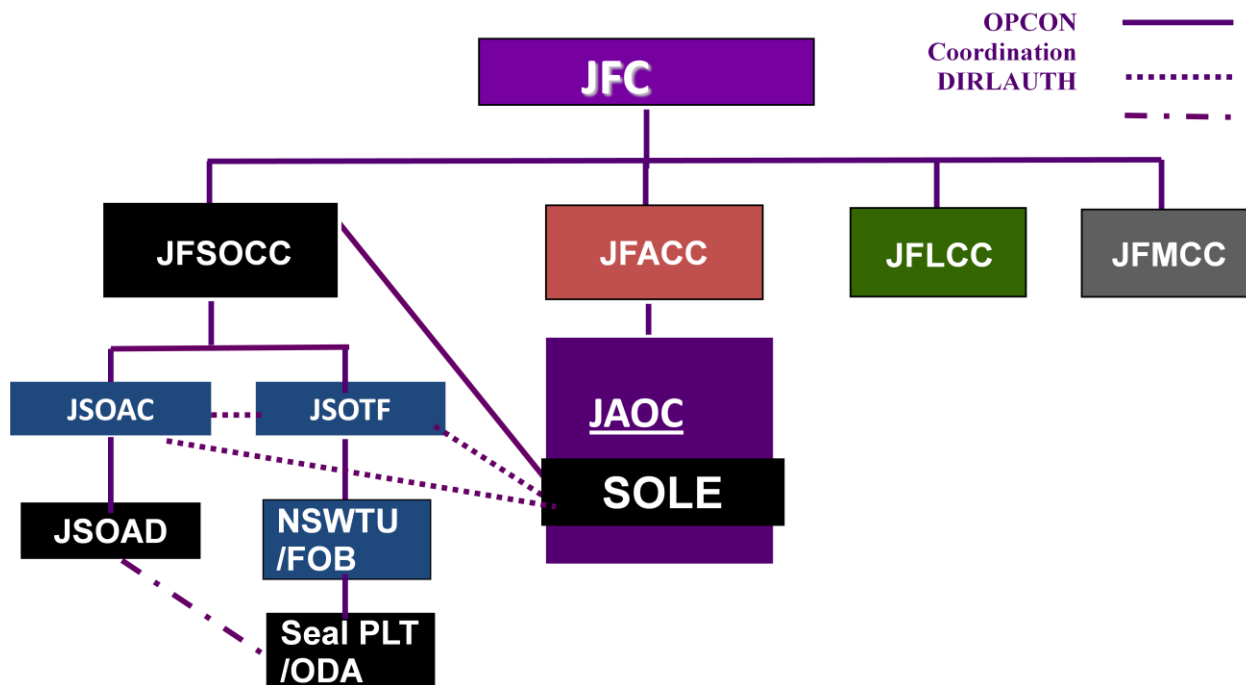
## **2.6. Medical Foreign Internal Defense/Combat Aviation Advisory (FID/CAA).**

International Health Specialist (IHS) personnel are imbedded in the AFSOC Medical Foreign Internal Defense/Combat Aviation Advisory program. These medical personnel deliver medical expertise in conjunction with CAA teams and medical training to support theater combatant commanders during contingencies and wartime deployments facilitating the health, safety and well being of forces and thereby improving combat effectiveness and interoperability. When deployed with a CAA element, they can provide medical support to theater combatant commanders during contingencies & wartime deployments using host-nation or theater assigned resources. They co-locate with host-nation aviation elements and assess, train, advise/assist counterpart host-nation personnel in the employment, sustainment and integration of host-nation medical operations. They may be required to provide medical liaison between U.S. and host-nation authorities.



## COMMAND, CONTROL, AND COMMUNICATION

### Figure 3-1 Joint Force Commander (JFC) Command Structure



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Health Service Support (HSS) for the Commander Joint Special Operations Task Force (CDRJSOTF) and SOF components. (JP 3-05.1)

**3.3. AFSOC UTC Assignment.** AFSOC operational medical UTCs are primarily assigned to AFSOC Operations Support Medicine (OSM) Flights. OSM personnel are UTC specific trained and equipped to support both the AFSOC flying mission as well as the medical support needs of deployed SOF units. OSM flights are assigned under Special Operations Support Squadrons (SOSS) and report through the SOSS chain of command to the Special Operations Group (SOG) and Special Operations Wing (SOW) commanders as SOF enablers. The SOSS commander appoints the OSM Flight Commander. The OSM Flight Commander should ideally be an Aerospace Medicine Specialist (48A3) or specialty trained Flight Surgeon (48R3).

**3.3.1. ARC Medical Units.** AFSOC UTC's assigned to the gained Air Force Reserve Component (AFRC) and Air National Guard (ANG) units are coordinated between AFSOC/SG and AFRC/SG or ANG/SG to insure support to the AFSOC mission while maintaining the parent Wing medical support capability.

### **3.4. Medical Command and Control.**

**3.4.1. Operational Medical C2.** Operational medical personnel fall under the command and control (C2) of Line of the Air Force Commanders of special operations units. At home station OSM personnel report to the SOSS commander, however, SOFMEs could also fall under the C2 of flying squadron commanders if assigned to that squadron as an SME. In either case, while deployed OSM personnel report through JSOAC and/or JSOTF commanders to the Theater Special Operations Commander to the COCOM Commander. AFSOC mission commanders maintain operational control of AFSOC operational medical personnel in order to support short notice and/or highly specialized missions and to ensure operational medics have the required training prior to being tasked to support such operations.

**3.4.1.1. SOF Alignment.** Doctrinally, AFSOC medics are deployed as part of an AFSOF, Joint Special Operations Air Component (JSOAC), or Theater Special Operations Command (TSOC) designated task force.

**3.4.1.2. Non-combatants Status.** AFSOC medical personnel deploy, in accordance with (IAW) appropriate Geneva Conventions/Law of Armed Conflict directives, as members of a USSOCOM or TSOC task force.

**3.4.1.3.** The AFSOC medics are an operational aeromedical support entity for the special operations air component rather than a conventional healthcare support element. As such, the AFSOC medics deploy under the operational control (OPCON) of the AFSOF or JSOAC commander rather than the TSOC or Joint Special Operations Task Force/Command Surgeon (JSOTF/SG). In some cases, AFSOC medics may be tasked separately to support a JSOTF/SG joint medical package. In other cases the SOFME may support both the JSOAC and the JSOTF. Furthermore, the most experienced deployed SOFME flight surgeon may be tasked to serve as the JSOTF/SG or JSOAC/SG.

**3.4.1.4. Joint Special Operations Air Component Commander (JSOACC) Control.** The JSOACC will normally maintain control of AFSOF, including medical personnel. When

AFSOC medical personnel are tasked to perform Joint Force Special Operations Component Commander (JFSOCC) missions, C2 should be through the JSOACC. Joint Operations C2 requirements: In the joint arena, AFSOC medical personnel will fall under the professional oversight of the SMO on the base or operating location, or where applicable, the JSOTF/SG. The JSOTF/SG is appointed by the Commander Joint Special Operations Forces Task Force (CDRJSOTF) to serve as the special staff officer responsible for establishing, monitoring, or evaluating joint force health service support for SOF.

**3.4.1.5. Medical Leadership.** Internal to the SOFME, the Flight Surgeon, regardless of rank, is ultimately the medical decision-making authority. In the tactical environment, the ranking team member acts as the tactical team leader for the SOFME.

**3.5. Concept of Medical Oversight.** It is imperative to the success of SOF medicine that everyone involved in response and treatment of casualties is trained and proficient to maintain the stated capabilities within this document. The cornerstone which links capabilities across the spectrum of SOF medicine is the proper execution of medical oversight and coordination. Medical oversight must be maintained at home station through joint exercises, daily preventive medicine programs and certification training program management. These programs will develop relationships which transition to medical oversight in an operational environment.

**3.5.1. Importance of Home Station Medical Oversight.** All operational AFSOC medical personnel are expected to provide and/or enable the best possible aeromedical (encompassing all aspects of team aerospace programs) and trauma care to SOF warriors in some of the most austere and remote tactical environments. AFSOC operational medical personnel first and foremost must be medically current and highly proficient. The most critical mission essential task of all AFSOC medics is the skilled, practiced and proficient delivery of aeromedical and trauma care. Furthermore, AFSOC medics must master the medical tactics, techniques, procedures, and skills necessary to provide the capabilities outlined in Chapter 2. The proper execution of medical oversight at home station ensures that the AFSOC medic is always well prepared to deliver appropriate medical care for SOF. Medical oversight must be maintained at home station to ensure AFSOC medical personnel appropriately participate in clinical medical care, daily preventive and aerospace medicine programs and certification sustainment training. It is critical squadron leadership ensures every OSM, special tactics, and aviation advisory medic's exposure to patient care opportunities and AFSC specific duties are maximized. Squadron commanders must foster a unit culture that recognizes the maintenance of practiced medical skills are critical to mission readiness and effectiveness. Bottom line: AFSOC medical personnel must always be proficient across the entire spectrum of aerospace medicine and SOF specific requirements.

**3.5.2. Deployed Medical Oversight.** Deployed Medical Oversight ensures appropriate medical care is provided for SOF. It complements but does not substitute for C2. Typically, direct deployed medical oversight is provided by the JSOTF/SG, and then Component Commander/Surgeon General (COCOM/SG) assuming those individuals are credentialed physicians. AFSOC medical personnel may fall under the professional medical oversight of a conventional medical commander (Expeditionary Medical Support [EMEDS], Combat Support Hospital [CSH], etc) when SOFMEs are deployed with non-SOF medical support units or when SOFMEs are deployed to a location with an established military treatment facility. In these instances, the deployed senior AFSOC medical officer will establish the framework for

cooperative effort. However, AFSOC medical personnel will remain under the Operational Control/Tactical Control (OPCON/TACON) of JSOAC, JSOTF, or TSOC commanders. AFSOC medical assets personnel will not CHOP to support non-SOF medical requirements. Furthermore, AFSOC medical personnel will redeploy with AFSOC forces when SOF missions and SOF requirements are completed.

**3.5.3. Establishing Deployed Medical Oversight.** It is the senior SOFME or AFSOC medical representative who maintains responsibility to establish a system for the collection of data from any and all caregivers rendering care to assigned or attached forces. All mission reports will be reviewed and lessons learned will be reported through situation report channels. Any SOF element deployed forward that does not have an embedded medical element will contact the nearest medical element SME to establish medical oversight coordination. It is recommended that any Special Operations Task Force maintain liaison relationships to the lead AFSOC Surgeon within an Area of Responsibility (AOR) to establish medical oversight protocols and procedures. It is important to understand this is a cooperative concept to ensure the highest quality of medical care to SOF forces and is not a direct command and control function.

**3.5.4. Cooperative Medical Oversight (CMO).** Special operations forces are limited by definition. CMO allows commanders to maintain effective medical coverage with utilizing forces efficiently. Joint training, standardized practices, and policies enhance the interoperability of AFSOC medical forces. Commanders must be aware, informed of, and trained to the medical capabilities needed and how to effectively and efficiently employ these support forces.

**3.5.5. Medical Data Collection.** The senior deployed SOFME medical officer has the responsibility to establish a system for the collection of data from all caregivers rendering care to assigned or attached forces. Medical record keeping will be IAW theater policy. All mission reports will be reviewed and lessons learned will be reported through JSOAC and/or JSOTF report channels to the SOFME's command chain (SOSS, SOG, etc.) with parallel reporting through the chain of command to 23 AF/SG and AFSOC/SG via the AFSOC Operations Center. Any AFSOC element deployed forward without an embedded medical element should contact the nearest SOFME and TSOC/SG to establish medical oversight coordination. The lead AFSOC surgeon within an AOR should establish liaison relationships with the Special Operations Task Force and with the Joint Survival Recovery Center (JSRC) to establish medical oversight protocols and procedures.

**3.5.6. Relationship with Theater Medical Authorities.** The AFSOC medics have a relationship with theater medical authorities. Although the AFSOC medics maintain command relationships through operational chains of command, they adhere to theater medical policies and requirements as established by the COCOM/SG and TSOC/SG.

**3.5.7. Communication Links and Medical Reporting.** The AFSOC medics have specific communication links and medical reporting requirements. AFSOC medical personnel communicate operational requirements through their OPCON/TACON chain of command and through the JSOTF/SG. Medical reporting/disease surveillance requirements are accomplished in accordance with published directives and theater policy. AFSOC medical personnel must be able to communicate with other AFSOC or SOF medics via secure intra-team radios, with other tactical SOF elements via secure line-of-sight communications and with SOG, SOW, TSOC, and AFSOC headquarters via secure beyond-line-of-sight communication as well as via secure and

non-secure internet access. The key to good communications and connectivity with other elements starts with good pre-deployment mission planning. SOFME personnel should coordinate deployed communications requirements with SOG communications planners. A SOFME cannot rely on conventional FOB support for its communications needs. SOFME's must be prepared to deploy with communications capability.

## Chapter 4

### EMPLOYMENT OF MEDICAL SUPPORT FOR SOF

**4.1. Deployment Concept.** The AFSOC medical UTC employment concept is to deploy appropriate UTCs in support of AFSOC/SOF missions. The SOFME is the initial building block (see Figure 4-1) for AFSOC/SOF medical support. The SOFME may be built upon as the contingency intensifies or as workload or the threat increases. Additional medical equipment and supplies can be provided by the RRDK (complete or partial) or SOF Base Medical Support as the workload, medical requirements or threat dictates. Additionally, AFSOC can readily increase its medical capability at a staging base by adding AFSOC SOST, SOCCET, and/or SOF Medical Element Augmentation packages. Conventional medical and/or AE assets may also be integrated with organic medical capabilities of special operations units to enhance the medical and AE support to the operation as needed.

**4.1.1. UTC Mission Capability Statements (MISCAPS).** Each AFSOC UTC has MISCAPS that support specific operational requirements. Equipment packages are designed for highly mobile and austere conditions. As mission requirements change, UTC packages (personnel and equipment) can be tailored (up or down), replicated, or combined with previously deployed UTCs in order to meet the new requirements. The planner must identify the actual resources required in order to accomplish mission requirements. In addition to choosing the correct package(s) to support the requirement, the planner must also strive to maintain smallest deployed footprint that adequately supports the mission requirement.

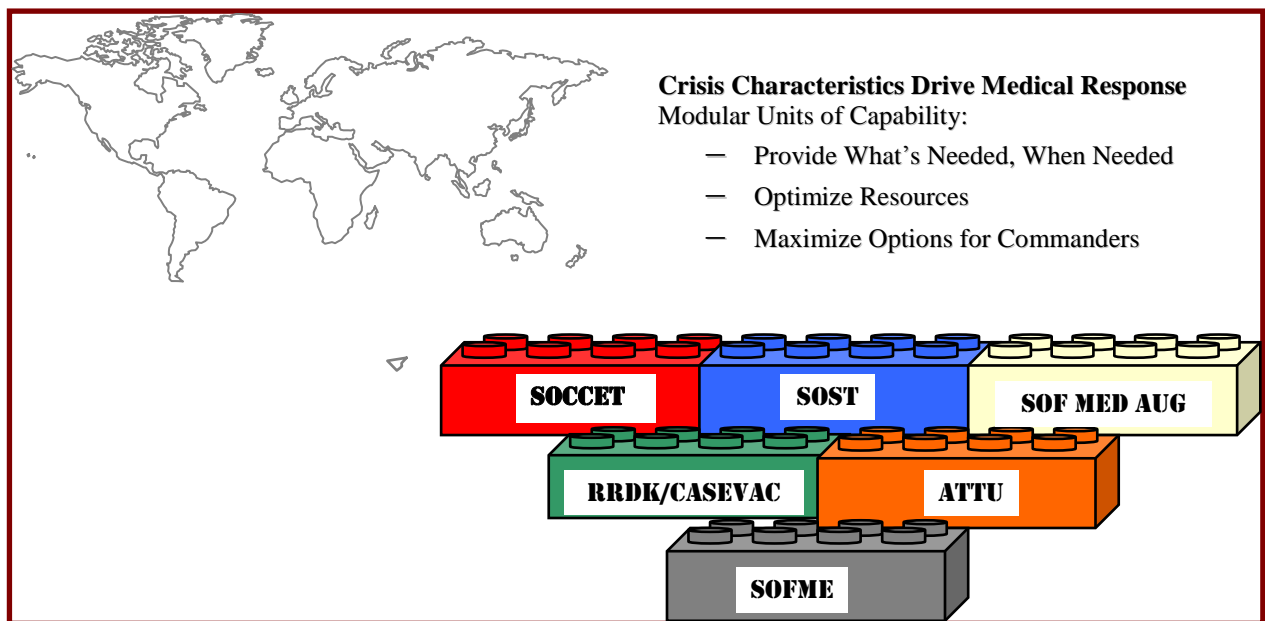
**4.1.2. Modular Employment Concept.** The AFSOC medical UTC employment concept is based on a modular building block approach that allows for the desired capability to be employed at the correct time and place in support of SOF missions. AFSOC medical personnel may be collocated with other JSOTF medical agencies to combine assets to ensure full spectrum health support for deployed AFSOF or other assigned/attached forces.

**4.1.3. Modular UTCs.** The AFSOC medical UTCs have been developed utilizing the modular (building block) concept. This concept allows planners to select specific UTCs that are tailored to support the requirements of a specific contingency or to support the requirements of a specific Operational Plan (OPLAN). The SOFME UTC is the fundamental module (building block) for deployed SOF operations. Other AFSOC medical UTCs (FFQEM, FFQEN, FFQEL, & FFQE8) augment the FFQEK as required in order to fulfill SOF medical support requirements.

**4.1.4. Medical Advanced Echelon (ADVON).** AFSOC medics bring unique capabilities to support the deployed joint SOF commander. SOFME personnel should deploy in advance of main forces to conduct in-theater site surveys of HN medical facilities, public health, health risk, and disease surveillance at deployed locations. The ADVON team should identify all medical assets (including other SOF medics/medical capabilities/PJs) in the AOR and begin to establish lines of communication. Medical personnel can be sourced for the ADVON from the FFQEK or FFQE8 medical UTCs or the JSOAC medical staff positions assigned to 9AAHQ UTC. The 9AAHQ UTC is an AFSOC Headquarters UTC that provides the core staff for the theater AFSOF for contingency and wartime requirements. Although not a medical UTC, three medical personnel (flight surgeon, medical operations/plans officer, and senior medical technician/operations noncommissioned officer [NCO]) are assigned to this headquarters UTC.

These medical personnel can serve as the medical staff advisors to the deployed commander and provide medical planning capability, command and control of the deployed SOF medical assets, SOF medical oversight with the senior flight surgeon serving as the SMO to the supported commander. The medical staff can be deployed in total or pared down to meet initial or recurring operational requirements.

**Figure 4-1 AFSOC Building Block Concept**



**4.2. Advantages.** A major benefit derived from the development of AFSOC medical modules is incremental deployment flexibility. As a result, medical deployment packages are tailored to the specific task/operation. Furthermore, even the RRDK can be deployed in whole or in part, and the SOF Medical Kit allows deploying SOFME medics to hand carry the initial medical response package on any organic aircraft or to palletize the medical kit with other mobility equipment. Follow-on medical equipment can be transported as airlift permits or by generating a separate airlift requirement. In essence, AFSOC medical capability can still be deployed even when airlift is limited.

### **4.3. Core Concepts of AFSOC Medicine in the Battlespace.**

**4.3.1. Forward Operating Base/Intermediate Staging Base (FOB/ISB) Base Operating Support (BOS).** The basic building block is the SOFME with tiered supply and equipment packages that accompany them. These tiers include the SOFME medical backpack, aircraft roll-packs and RRDK which are the initial building blocks for AFSOC medical support and may be built upon as the contingency intensifies or as workload increases. The amount of basic care and clinical oversight responsibilities are based upon a population at risk assessment. The SOFME

augmentation package brings additional BOS assets and expertise in preventive medicine, medical plans and logistics and limited CBRNE patient decontamination. The number of SOFME teams deployed will greatly depend on the mission although BOS medical support will remain constant no matter how many teams are deployed.

**4.3.2. Casualty Evacuation (CASEVAC).** The SOFME's secondary operational mission is CASEVAC; stabilize and transport (with en-route medical care) patients from battlefield forward locations to advanced medical care facilities using vehicles/aircraft of opportunity. The CASEVAC package and RRDK provide equipment and supplies to perform casualty evacuation in austere environments. The basic CASEVAC capability of the SOFME can be enhanced with support from the special operations critical care transport team (SOCCET) however; the SOFME is trained and equipped to be the first option.

**4.3.3. Advanced Surgical/Critical Care and Transport.** This capability is met by adding SOF Surgical Teams (SOSTs) and SOCCETs to provide a far-forward surgical intervention, stabilization and patient holding and transport capabilities. These teams in combination with other joint medical support assets can provide a robust critical care capability.

**4.4. Casualty and Disease Management in SOF Operations.** The SOF mission requires medical preparation to stabilize injured or seriously ill members while moving them towards definitive care. This may occur in environments quite distant from acceptable sources of definitive care and distant from conventional aeromedical evacuation support. AFSOC deployed capability for management of disease and injury can be characterized by four phases: 1) SABC; 2) initial response; 3) stabilization and treatment; and 4) CASEVAC. Phases two through four may overlap and occur simultaneously to varying extents, depending on the scenario. If movement by air is immediately available and/or rendered urgent by the tactical situation, stabilization may occur during CASEVAC. The SOFME provides casualty and disease management during SOF operations to stabilize injured or ill patients while moving them to/towards definitive care. The SOFME is responsible for phases 2 through 4.

**4.4.1. PHASE I - Self Aid and Buddy Care (SABC).** SABC is the foundation of the medical care system. Properly trained and equipped non-medical personnel are able to provide initial lifesaving first aid in the absence of trained medical professionals or assist medical professionals during a mass casualty situation. SABC is especially critical for AFSOC forces due to the limited number of AFSOC medics. All AFSOC personnel receive Self-Aid and Buddy Care training IAW Air Force directives. High risk units complete Tactical Combat Casualty Care (TCCC).

**4.4.2. PHASE II - Initial Response--Special Tactics Pararescue Support.** Air Force Special Operations Command Pararescue personnel (PJs-AFSC 1T2XX) perform advanced battlefield trauma care and emergency medical treatment while in the performance of special operations missions. Special Tactics pararescue personnel are specifically trained for combat surface operations either independently or in conjunction with Special Forces, Combat Control, Rangers, and Sea-Air-Land (SEAL) Teams. Although they do not hold medical AFSCs, the medical care rendered by AFSOC Pararescue personnel falls within the professional purview and oversight of AFSOC/SG, through the 720th Special Tactics Group Surgeon. Additional AFSOC Pararescue capabilities include:



- Functioning as initial responders in support of far forward personnel recovery operations.
- Conducting casualty collection operations during Direct Action (DA) missions or in hostile/denied areas.
- Providing the vital link in the transition process from Personnel Recovery – Combat Search and Rescue (PR-CSAR) field missions to the casualty evacuation system.

**4.4.2.1. Transload.** Pararescue specialists provide the vital link in the transition from direct actions or PR-CSAR field missions to definitive care platforms. Whenever possible this phase is rapid and short term. However, when recovery/rescue operations are conducted over large geographical distances, pararescue resources must be returned to action rapidly, or advanced medical transport care is required, transition of patients to a CASEVAC mission may have to be conducted. This transition is defined as a transload and can only be accomplished through concise pre-coordination with medical and operational planners. Transload operations must be coordinated and exercised in order to ensure the highest level of patient safety and clinical care. It is important to note that care must be taken to ensure accurate patient information must be passed along. It is the PJ team leader who is responsible to ensure that all pertinent patient information is passed to any subsequent care provider and to appropriate command and control agencies.

**4.4.2.2. Medical Personnel Considerations.** In intermediate situations where tactical extraction and initial stabilization are necessary under high threat but less than active combat conditions, PJs in combination with SOFME assets can be used to provide greater monitoring and treatment capability and would provide a high level of medical capability immediately to the casualties. Environments where extended transport time (over two hours) are expected or there is known disease component along with the trauma or other complicating medical factors may be part of the injury scenario, SOFME and/or SOCCET assets should be considered.

**4.4.3. PHASE III - Casualty Stabilization and Disease Treatment.** Casualty stabilization is aimed at achieving a stable airway, control of hemorrhage, treated shock, and splinted fractures. Stabilization begins with the first responders and continues as the casualty is transferred to the care of the SOF Medical Element flight surgeons and technicians and moved towards definitive care. Serious disease requiring evacuation is stabilized and moved in the same fashion. Stabilization can become a prolonged phase lasting over 24 hours if host-nation care is unacceptable and strategic aeromedical evacuation is not immediately available. Independent duty medical technicians and flight surgeons in the SOFME manage less serious disease amenable to treatment in the forward setting.

**4.4.3.1. Stabilization Surgery and Critical Care Treatment.** Stabilization surgery, performed by the Special Operations Surgical Team (SOST), is aimed at achieving a stable airway, controlling hemorrhage/internal bleeding, and stabilizing orthopedic injuries. The Special Operations Critical Care Evacuation Team (SOCCET) provides medical management of pre and post-op/stabilized patients (sometimes for prolonged periods of time -72 hours) and will be responsible for preparing and transporting these patients on CASEVAC or conventional AE missions. Conventional AE mission will require patient regulation through the Patient Movement Requirements Center (PMRC) assigned to the operational AOR.

**4.4.4. PHASE IV - CASEVAC.** CASEVAC is defined as the non-regulated movement of patients from either the point of injury or a transload site to a point where they enter the regulated patient movement system or definitive medical care system (see Figure 4-2). Special operations security considerations and mission constraints may preclude the establishment of traditional AE and medical regulating systems far forward. AFSOC has organized, trained, and equipped SOFME and SOCCET assets to meet this requirement. AFSOC medics will provide definitive circulation and airway management (i.e., hemorrhage control, fluid and blood resuscitation, and ventilator management) as well as detailed medical monitoring and administration of medications during transport. Responsibility for the planning and coordination of CASEVAC and AE of SOF rests with the supported commander and/or joint special operations task force (JSOTF) surgeon. AFSOC has the following capabilities to support CASEVAC forward of established AE systems and depicted in Figures 4-2 below:

**4.4.4.1. PJ/SOF Medic Interoperability.** Special Tactics PJs are line combatant rescue specialists with medical trauma management training and capabilities. It is critical that PJs and SOFMEs maintain interoperability in mission overlap areas, specifically, CASEVAC and en route medical care. PJs are capable of performing basic CASEVAC; however, the significantly higher level of medical care provided by SOFME CASEVAC must be considered during mission planning. Patients under the care of PJs will always be passed to SOFMEs or other higher levels of medical care as soon as possible. This ensures patients receive increasingly higher levels of medical care and facilitates keeping PJ assets available to execute the PJ-specific mission.

**4.4.4.2. Transload Operations.** The SOFME has the expertise and advanced medical capabilities to receive casualty hand-offs from ground combatants, PJs, Special Forces (SF) and SEAL medics. This transition/medical transloading may occur at a helicopter landing zone (HLZ) or remote contingency airstrip, but can occur at any location where SOF aircraft can land. Medical transloads are most effectively accomplished through precise pre-coordination with mission planners. Thus, medical transload operations must be a dedicated aspect of every pre-deployment CASEVAC planning consideration.

**4.4.4.3. Risk Management.** Since AFSOC medical assets are limited, task force surgeons and commanders must carefully consider available resources when assigning personnel to CASEVAC roles and other contingency taskings forward of the ISB. Appropriate risk management processes must be considered when determining the optimal utilization of the SOFME. Appropriate tailoring of force size and composition during the predeployment planning phases will greatly assist in ensuring availability of the required medical resources to meet operational requirements.

**4.4.4.4. Medical Mission Constraints.** AFSOC aircraft configuration and mission profiles limit the extent of medical care which can be provided during flight from an objective area to the ISB/FSB where more definitive care is available. Considering the constraints of the tactical environment, the following guidance is provided in order to select appropriate AFSOC medical crewmembers for CASEVAC missions:

**4.4.4.5.1.** SOFME flight surgeons and/or IDMTs or SOCCET personnel are specifically trained and may be tasked to support CASEVAC missions, as determined by the designated deployed SOF medical commander and the mission commander.

**4.4.4.6.2.** IDMTs should be the first choice and option when planning and executing any CASEVAC mission. When only one physician is available at the ISB/FSB, commanders must evaluate the risk and mission requirements in order to determine whether the physician should be utilized onboard the CASEVAC aircraft or at the ISB/FSB.

**4.4.4.7.3.** There are several scenarios where utilization of a physician or physician extender may be particularly advantageous in supporting CASEVAC mission requirements. These include scenarios where the increased level of care provided by a physician can reasonably be expected to improve the outcome above that of an enlisted medic, PJ or physician extender. Additionally, medical support requirements for “precious cargo” missions may be such that the medical care expected/required exceeds the medical skills/abilities of enlisted medics, PJs or physician extenders.

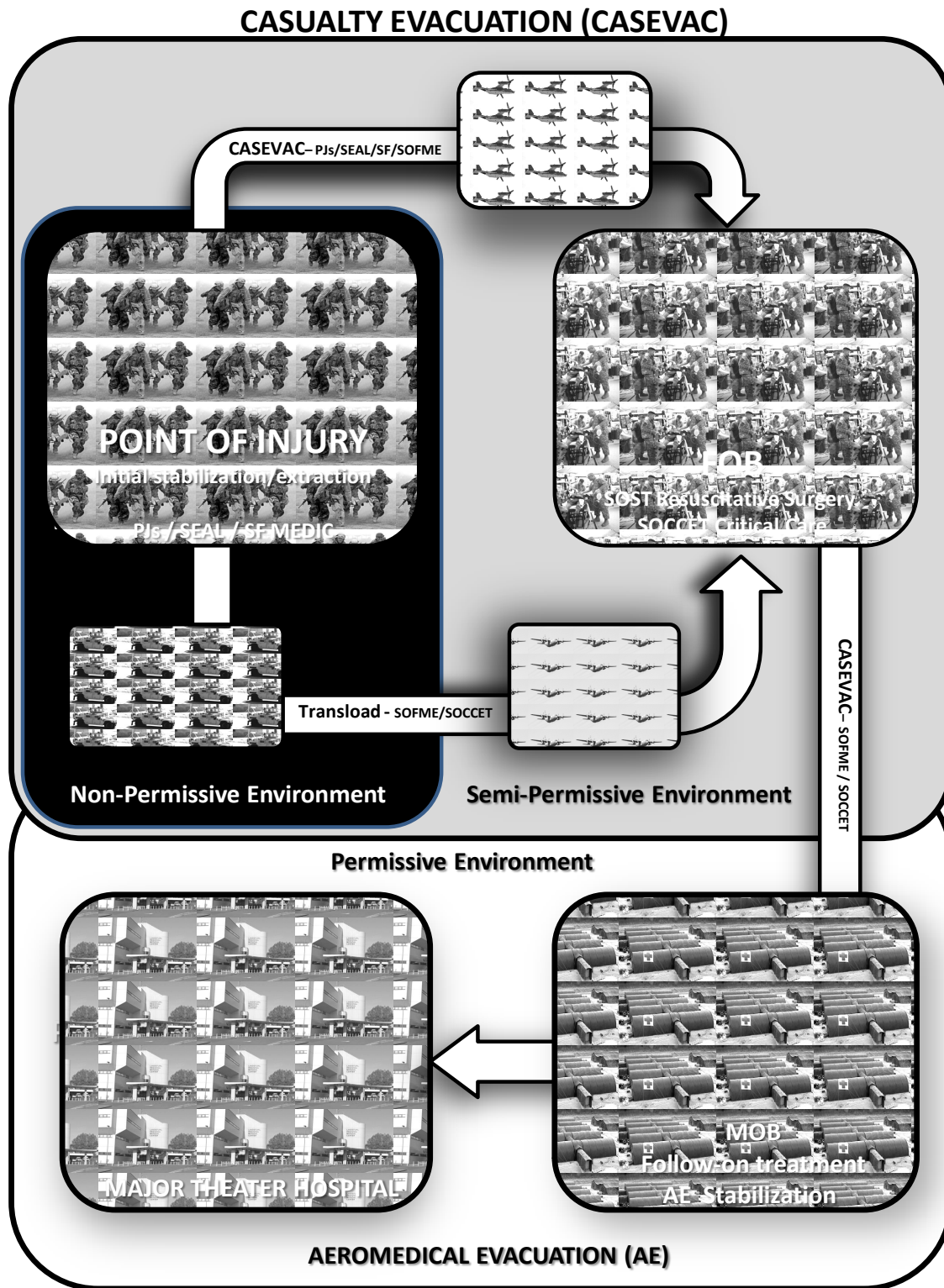
**4.5. Casualty Movement.** AFSOC OSM flight personnel are trained in contingency AE procedures and are qualified to provide casualty evacuation support. If the tactical situation permits and with the approval of the senior AFSOC line commander, AFSOC medical flight personnel can provide casualty evacuation support on AFSOC weapon systems or other opportune aircraft from secured objective locations to SOF operating bases.

**4.5.1. Aircraft Familiarization.** OSM flight personnel have the capability to configure AFSOC aircraft and other aircraft of opportunity and provide en route medical stabilization support and intervention until a transition to the established conventional medical and AE systems can be accomplished.

**4.5.2. Limited Medical Assets.** Since AFSOC medical assets are limited, commanders must carefully consider available resources when assigning AFSOC medical personnel to CASEVAC roles and other contingency taskings forward of the AFSOC force bed-down. Sound risk management processes must be considered when determining which is the best resource to provide this capability. Appropriate planning and tailoring of force size during the predeployment planning phases will greatly assist in ensuring availability of the required medical resources to meet operational requirements.

**4.5.3. SOFME Use for CASEVAC.** Utilization of the SOFME for CASEVAC missions provides an additional medical capability for deployed SOF forces. Operational security considerations, tactical considerations and mission constraints often preclude the establishment of traditional AE and medical regulating systems for SOF. Consequently, SOFME personnel are trained in contingency SOF CASEVAC procedures and are qualified to provide casualty evacuation support. If the tactical situation permits, the SOFME can provide CASEVAC support onboard SOF aircraft or other opportune aircraft. The SOFME has the capability to configure AFSOC or opportune aircraft IOT provide en route ATLS/ACLS medical care until the patient(s)/casualty(ies) can be transitioned to a higher level of medical care and/or the conventional AE system. The utilization of SOFME CASEVAC leverages AFSOC’s ability to recover and provide medical care for injured/ill personnel.

Figure 4-2 CASEVAC Process from Point of Injury to Definitive Care



## Chapter 5

### PLANNING CONSIDERATIONS

#### 5.1. SOF Operational Environment Medical Planning Considerations.

**5.1.1. Comprehensive Medical Planning.** The SOF casualty care system begins with pre-deployment activities that include identification of the PAR and the medical requirements and medical intelligence gathering required to support the PAR. The AFSOC planner translates the requirements into a plan by identifying HN medical facility capabilities, coordinating support with the AE system, and coordinating with joint Health Service Support agencies or deployed medical assets.

**5.1.2. Medical Intelligence.** AFSOC medical planners have access to multiple intelligence resources and gathering methods, to include Public Health resources, National Center for Medical Intelligence (NCMI), Defense Intelligence Agency (DIA), and coordination with supported theater/JSOTF medical planners.

**5.1.3. Medical Integration.** AFSOC medical forces are not organically equipped to perform extended medical operations or medical logistics support. Situations may mandate the close integration, coordination, and cooperation between AFSOC medical personnel and those within the established operational theater. As mission requirements allow, and with the approval/coordination of the AFSOC line commander, AFSOC medical forces will integrate with other deployed medical resources to maximize the overall base medical readiness posture.

#### 5.2. AFSOC Interface with Medical Contingency Ground Support Systems.

**5.2.1. Aerospace Medical Contingency Ground Support System.** This system includes the SMEs and independent duty medical technicians (IDMTs) assigned to operational units or remote sites, and represents the cornerstone of medical support to Aerospace Expeditionary Force (AEF) forces deployed in any worldwide contingency. Any assigned or attached unit to a Joint Task Force which owns a medic will coordinate with the Senior SOFME deployed to the assigned AOR. Medical oversight and coordination are required to ensure efficient use of limited medical assets in theater.

**5.2.2. AFSOC Medical and EMEDS Integration.** It is imperative that all AFSOC medical personnel and planners understand the capabilities inherent with each component, and specifically the HSS capability available during each phase of the EMEDS buildup. This will typically be the first interface point with medical units possessing enhanced clinical capabilities and inpatient beds. Components of the Aerospace Medical Contingency Ground Support System are utilized to provide essential medical/dental care, deferring definitive care as dictated by theater medical Concept of Operations (CONOPS). (Refer to AFTTP 3-42.7)

**5.2.3. SOF Casualty Management.** Once admitted to the medical treatment facility, SOF casualties are not always managed, regulated, or evacuated similar to conventional forces. SOF personnel normally have a separate evacuation policy to prevent personnel with critical specialties from being evacuated out of theater. SOF missions are often politically sensitive, there may be a requirement to safeguard the patient's identity, to prevent any compromise of the

unit's presence or jeopardize the operational mission. If requirements to safeguard patients' identities exist, prior coordination with the JTF/SG should occur to determine appropriate AE procedures.

### **5.3. Interface with the Aeromedical Evacuation (AE) System.**

**5.3.1. Movement of SOF Casualties.** Evacuation procedures employed are dependent on the special operations mission and the presence of a developed HSS system. The techniques, procedures, and equipment used to evacuate and/or extract casualties are consistent with the nature of SOF missions both principal and collateral. For additional information on evacuation procedures based on particular SOF missions, reference Joint Publication 4-02.2, *Joint Tactics, Techniques and Procedures for Patient Movement in Joint Operations, specifically Chapter IV "Special Operations Patient Movement."*

**5.3.2. AE/SOF Planning Considerations.** Planning should also address the interface with the AE system for patient movement requirements. AE for SOF may be difficult because of far forward operating locations; however, if operationally directed, AE may be tasked to go as far forward as there is a suitable airstrip. Operations at remote locations in immature theaters not served by the strategic AE system require close coordination between the supporting Air Force component command and joint medical planners. AFSOC designated AE elements may be collocated with organic medical capabilities of special operations units to facilitate the AE process. It is important to note that patient movement planning is complicated by the nature of special operations missions that require operational security measures precluding immediate patient movement to eliminate the signature of forces in sensitive areas or compromise mission accomplishment. AFTTP 3-42.5 may also be used as a reference.

**5.3.3. AFSOC AE Planning.** AFSOC does not possess organic conventional AE capability and must identify requirements for and obtain conventional AE support. As the air component surgeon to USSOCOM, AFSOC/SG has the responsibility for identifying and coordinating SOF AE requirements. Contingency planning should include the movement of patients from forward or remote areas back to military or HN's medical treatment facilities that have the capabilities to provide the appropriate level and standard of care. Additionally, contingency planning should address the interface with the conventional theater and inter-theater AE system for patient movement requirements.

**5.3.3.1. SOF/AE Integration.** Integration of SOF and the AE system is very likely. Contingency and crisis action planning match SOF missions to SOF and conventional AE capabilities. SOF missions require a flexible response. Therefore, conventional AE units tasked to support SOF missions may occasionally be required to modify or adjust their operational concepts to meet SOF mission requirements. An AE planner may be an active participant in the planning process. The JSOTF surgeon and medical planner will develop and coordinate all patient movement support requirements with AE planners. Conventional AE units need not obtain SOF type equipment. Proficiency in their Mission Essential Tasks List (METLs) and UTC MISCAPS will be the basis for developing roles and missions but adjusted if required to support SOF operations.

**5.3.3.2. AE/SOF Doctrinal Differences.** Doctrinal differences from SOF and AE will be addressed in the planning process. SOF does not utilize patient movement items (PMI) assets

and provides limited documentation on casualties. Predetermined PMI may need to be placed at FSB and ISBs. There is no medical regulating of patients from forward areas and patients may be moved to pre-designated MTFs. SOF medical equipment is limited and may not move with the patient. Little or no medications will accompany patients. AE UTCs may require paring and tailoring to support SOF missions. The concept of operations can be fluid until the mission execution point.

**5.3.3.3. AE Availability.** In a major contingency, conventional AE will be available at either an FSB or ISB, depending on the scenario. In a SOF-only operation (or exercise), conventional AE may not be available. In these instances, the deployed SG is left with three options: 1) hold the casualty at the deployed location and wait for conventional AE; 2) use HN medical support; or 3) continue transport via SOF opportune aircraft to a location where link with the conventional AE system is available. In some scenarios, AE elements could be tasked to deploy along with SOF medical assets to support SOF patient movement requirements. The patient movement option chosen will depend on the condition of the casualty as well as the availability of both SOF and conventional aircraft for casualty transport.

## **5.4. Mission Planning.**

**5.4.1. Medical Planner.** Mission planning is paramount to the successful execution of exercises, deployments, and operations. Due to the diversity of the geographic areas of responsibility that SOF transgresses and the customers that AFSOC supports, each OSM flight has a designated medical planner to ensure the needs of the mission are met. The OSM flight planner coordinates the SOF casualty care system, logistics, and operational support with headquarters, joint, and theater planners. PJ team leaders play a vital role in operational planning and can offer guidance to medical planner as to care available, transport options, operational environment and ongoing operations.

**5.4.2. Provision of En Route Care in the Tactical Environment.** AFSOC aircraft conditions and mission profiles limit the extent of medical care that can be provided during flight from an objective area to the ISB/FOB where more definitive care is available. Given the constraints of the tactical environment, specific consideration should be given when planning the crew for CASEVAC missions.

**5.4.2.1. CASEVAC Support.** Physicians, physician extenders, and medical technicians may be tasked to support CASEVAC missions, as determined by the deployed medical commander and the mission commander. EMT-P trained medical technicians are normally the primary medics tasked to support CASEVAC missions.

**5.4.2.2. Operational Clinical Oversight.** There are several scenarios where utilization of a physician or physician extender may be advantageous in supporting CASEVAC mission requirements. These include situations where the physician/physician extender can clinically improve the casualties' condition beyond medical technician capabilities. Also, medical support requirements for "precious cargo" missions may be such that the medical care expected and required exceeds available capability.

**5.4.2.3. Loss of Forward Medical Support.** When only one physician is available at the ISB/FOB, commanders must consider where the greatest capability is needed either on the CASEVAC aircraft or at the ISB/FOB.

**5.4.3. Non-combatant Assets.** Medical personnel and equipment are non-combatant assets. However, AFSOC operational medical personnel train in small unit tactics, weapons use, and all appropriate combat skills for the SOF environment. They deploy armed to defend themselves and their patients according to mission requirements. AFSOC medics can be incorporated into a special operations unit without degrading the capability of the operation. Overall security for the AFSOC medics and their patients is the responsibility of the forces securing the ISB/FOB or the supported team. Medical site assets and patients will be protected as a controlled area in accordance with AFI 31-101, *The Air Force Installation Security Program*. Medical personnel should never be placed in an offensive role.



## Chapter 6

### MEDICAL LOGISTICS SUPPORT AND WAR RESERVE MATERIEL (WRM)

#### 6.1. Medical Logistics Support for Special Operations UTCs and Medical WRM.

**6.1.1. Purpose.** AFSOC WRM assemblages provide extensive medical supplies and equipment needed to support combat casualty initial treatment, transport, and the prevention of disease and non-battle injuries (DNBI). All AFSOC WRM assemblages are packed to a standardized allowance standard (AS) to ensure interoperability between AFSOC medical personnel.

**6.1.2. Deployment Planning.** During initial deployment planning, theater medical planning guidance generally requires units to deploy with a 30-day package of medical supplies. For AFSOC units, the deployment load will vary based on mission requirements and operational constraints. To determine medical logistic requirements, medical planners must consider the mission and its duration, the availability of supplies at the mission location, and the alternate medical supply sources available in the event the conventional supply system breaks down.

**6.1.3. AFSOC Medical Logistics.** AFSOC medical forces currently possess limited logistical support capabilities. In many SOF operations the nature of the operation (covert, short-term, etc.) will not allow or require a resupply mechanism to be established. During Covert/Clandestine Operations adequate medical supplies and equipment are deployed with AFSOC medical units to ensure capability exists to support operational requirements. When resupply is required, SOF medical planners establish resupply through a variety of mechanisms to include: (1) support from a host medical treatment facility; (2) in-country embassy or Military Assistance Group (MAG); and (3) home station or main operating base. When deployed in support of a major regional conflict, AFSOC medical logistics support is provided by the conventional HSS system. Prior coordination with host medical treatment facility or JTF/SG will help ensure adequate medical logistics support is available.

**6.1.4. Medical Planning.** Medical involvement in all phases of mission planning is essential for mission success. AFSOC logisticians working with line and medical planners have the requirement base to plan and predict the acquisition and flow of supplies and maintenance of WRM that special operations medics will require. Their knowledge allows essential strategies to be formulated to ensure adequate equipment and supplies for the deployed SOF medical assets. Thus medical resupply requirements are driven entirely by the planned mission. Consequently, such operations may require particularly careful coordination to ensure resupply when and if necessary. AFSOC medical logistics are normally coordinated through the Combined Joint Special Operations Air Component/Surgeon General (CJSOAC/SG) medical plans officer and/or JSOTF/SG medical plans officer and provided by the nearest conventional medical logistics unit if the teams are in a mature theatre. If the AFSOC medical assets are located in an immature theatre, the team will reach back to home station for resupply or will coordinate resupply using local or regional resources when appropriate. Otherwise, the TSOC/SG office is responsible for the medical logistics supply chain. Cost estimates should be provided in the preliminary planning process to ensure reconstitution of all AFSOC WRM assets. Resupply must be addressed in the predeployment planning process. AFSOC medical supply costs are funded by the supported unit(s), and reimbursed when possible from operations, exercise, or contingency funds.

**6.1.4.1. Medical Logistic Objectives.** Logistic objectives are to reduce the physical footprint for deployment without degradation of medical capability, maintain portability, and provide a logistics support system to ensure responsive sustainment. In many SOF operations, the short term, covert or low-visibility nature of the operation will not permit the establishment of a standard resupply mechanism.

**6.1.4.2. Medical Logistics Planning.** When deployed in conjunction with AFSOC equipment UTCs, AFSOC medical assets are normally capable of providing medical support to a deployed AFSOC unit for up to 30 days without resupply. Consequently, such operations may require particularly careful coordination to ensure resupply when and if necessary. SOF medical logistics are normally coordinated through the SOF medical plans officer and are provided by the nearest conventional medical logistics unit if the SOF medics are deployed to a mature theatre. If the SOF medics are located in an immature theatre, the team will coordinate resupply using local or regional resources when appropriate. Predetermined PMI may need to be placed at forward or intermediate staging bases.

**6.1.5. Reconstitution.** All AFSOC medical WRM packages are maintained in a "ready to deploy" configuration. Medical supply and equipment packages returned to the unit following deployment will be reconstituted in order to meet required response times in Designed Operational Capability (DOC) statements. UTCs must be maintained to 90% readiness posture for critical items.

**6.1.6. Rebuilding.** Documentation of medical supplies and equipment used/expended during any training or operational deployment will be maintained by AFSOC medical personnel to assist in the recovery of after-the-fact (ATF) funding as required. Details and specifics of logistical support will be provided and will be identified in applicable base support plans. Established AFSOC medical assemblage allowance standards will be modified through recommendations of the pilot units, as appropriate. AFSOC medical assemblages are specifically designed for rapid load planning, deployment, employment, and reconstitution.

## **6.2. Medical Supplies and Equipment Operations.**

**6.2.1. Initial Deployment.** Theater medical planning guidance generally requires units to deploy with a 30-day package of medical supplies. The initial deployment load for AFSOC units will vary based on mission requirements and operational constraints. To determine medical logistic requirements, medical planners must consider the mission and its duration, the availability of supplies at the mission location, and the alternate medical supply sources available in the event the conventional supply system breaks down. AFSOC medical forces currently possess limited logistical support capabilities. AFSOC medical units have medical stock record accounts at home station, but may depend on local base/host medical treatment facilities for various types of medical logistics support, linen control (as applicable), and biomedical equipment repair support.

**6.2.2. Re-supply.** In many SOF operations the nature of the operation (covert, short-term, etc.), will not allow or require a resupply mechanism to be established.

**6.2.3. Sustainment Operations.** When deployed in support of a major regional conflict, AFOSF medical logistics support is provided by the conventional HSS system (reference AFTTP 3-42.8, *Medical Logistics and Blood Support Operations*). Prior coordination with host medical treatment facility or JTF /SG will help ensure adequate medical logistics support is available.

**6.2.4. SOF Medical Logistics Supply Chain Essentials.** Medical logistics personnel must be familiar with the following supply chain methods and programs to ensure SOF forces maintain adequate supplies for long periods of time: Government Purchase Cards (GPC) programs, Theater Lead Agent for Medical Materiel (TLAMM), Department of Defense Acquisition Code (DODAC), Area of Responsibility (AOR) funding programs, Theater equipment Loaner Replacement and Repair Center (LRRC).

**6.2.5. Patient Movement Items (PMI).** The PMI supports in-transit patient care capability without removing equipment from patients or depleting forward medical units of critical medical equipment and supplies. The system exchanges like-kind equipment without degrading capabilities, and provides prompt recycling of PMI. The system provides a seamless in-transit visibility equipment management process from initial entry into AE to the patient's final destination.

**6.2.5.1. PMI Support.** The PMI system UTCs deploy in support of and are collocated at key interface points to provide an initial capability, to sustain AE operations, and to minimize equipment turnaround time. Equipment will be managed, and supplied through the PMI centers and joint transportation and logistics systems. The originating health care facility is responsible to provide the PMI required and to support the patient during evacuation. Services should plan, program, and secure equipment that is air certifiable to use in deployable platforms. In a contingency, the PMI cell may be collocated with the TLAMM, normally at a robust air and logistics hub.

**6.2.5.2. PMI Program Oversight.** While the PMI program is mandated by the Assistant Secretary of Defense (Health Affairs), the USAF/SG has oversight responsibility, and Air Mobility Command (AMC)/SG has program management responsibility. MAJCOM and theater surgeons (TSG) are executive managers of PMI within their areas; i.e., AMC/SG, Pacific Air Force (PACAF/SG), USAFE/SG.

**6.2.6. Theater Lead Agents for Medical Materiel.** In overseas theaters, these organizations have historically included Army medical materiel centers (MMC) that provide comprehensive medical logistics support to both institutional MTFs and contingency operations. Defense Logistics Agency (DLA) recognized the value of these theater medical logistics organizations leading to their designations as TLAMM. Currently, the Chairman of the Joint Chiefs of Staff (CJCS), on recommendation of the DLA Director, has approved TLAMM designations for each Geographic Combatant Command (GCC) as follows:

Combatant Command	Designated Theater Lead Agent for Medical Materiel (TLAMM)
USEUCOM	US Army Medical Materiel Center – Europe (USAMMCE)
USAFRICOM	
USCENTCOM	US Army Medical Materiel Center–Southwest Asia (USAMMC-SWA)
USPACOM	
USFK	US Army Medical Materiel Center – Korea (USAMMC-K)
Outside USFK	18 <sup>th</sup> Medical Group (Kadena Air Base)
USNORTHCOM	US Army Medical Command
USSOUTHCOM	Air Force Medical Operations Agency, Medical Logistics Division

Theater Lead Agents support the GCC and its Service components, as well as DLA, in planning and execution of medical supply chain support and provide a single point of contact for medical logistics support to theater medical forces.

**6.2.7. Blood and Blood Products.** The Armed Services Blood Program is a DoD level function governed by Department of Defense Instruction (DoDI) 6480.4, *Armed Services Blood Program (ASBP) Operational Procedures*. Other key references are, Air Force TTP 3-42.711, *Blood Support Operations*, AFI 44-105, *Air Force Blood Program*, AFJH 44-152, *Armed Services Blood Program*, *Joint Blood Program Handbook*, the Special Operations Forces medical handbook, and the theater specific blood program guidance are key references for SOF medics in managing and administering blood and blood products in a deployed environment. AFSOC operational medical units will establish local policies and procedures for use, storage, and re-supply of blood and blood products. AFSOC operational medical units will incorporate the use of blood and blood products in their training.

**6.3. Integration.** Integration of the deployed AFSOC medical assets with other SOF component medical teams, as well with the line special operations units is necessary to facilitate required expeditionary combat support (ECS) and, AE support.

**6.3.1. ECS Support.** ECS requirements may include, but are not limited to, power, messing, water, fuel, billeting, transportation, communication, logistics, security, medical oxygen and operational funds.

**6.3.2. AE Support.** Rapid patient evacuation is essential to mission success. SOST and SOCCET equipment and supplies are interoperable with critical care air-transport teams (CCATT) in-flight kits and EMEDS assets. However, the teams are not capable of furnishing medical supplies and equipment to patients during the conventional AE process when not accompanying the patient. Medical involvement in all phases of patient movement mission planning is essential for mission success. Early CASEVAC to definitive care will enhance patient survivability and mission success. Integration with the conventional AE will improve patient survivability.

**6.4. Ground Transportation Consideration.** AFSOC medics at ISB/FOBs require vehicles that can function as patient transport vehicles/ambulances, medical response vehicles and to move medical equipment as needed.

**6.5. Additional support.** The medical planning officer/NCO interfaces with TSOC and AFSOC staff to plan for and coordinate medical readiness, medical logistics, and mission planning needs of the AFSOC medical assets.

## Chapter 7

### TRAINING

**7.1. Objective.** The overall objective of SOF medical training programs is to develop and maintain a high state of mission readiness of AFSOC medical personnel for rapid employment across the spectrum of SOF operational requirements. AFSOC medical personnel interface with conventional, nonconventional, joint, coalition medical forces and conventional patient movement systems as dictated by circumstances and requirement. AFSOC medical personnel must be interoperable with all other SOF medical personnel. AFSOC medics must be trained to perform their roles at night, during low-light or blackout conditions, in environmental extremes and in combat environments. The overarching goal is for AFSOC mission commanders to have the operational control of the medical assets required to support short notice and/or highly specialized missions and to ensure these personnel have the required training prior to being tasked to support such operations.

**7.2. Responsibilities.** AFSOC/SG is lead command designee for training course requirements, training tasks, and coordinating the development and publication of SOF medical training standards. AFSOC/SGPO is the OPR for clinical and operational medicine issues that impact non-aerospace medicine deployed medical forces while AFSOC/SGP is the OPR for all aerospace medicine issues. The SGP represents AFSOC at the Pararescue Medical Oversight Advisory Board (PJ MOAB) to address clinical and operational medicine issues that impact pararescue forces.

**7.3. Medical Training Requirements.** AFSOC medical training is tailored to each member's specialty. The overall objective of SOF medical training programs is to develop and maintain a high state of mission readiness of AFSOC medical personnel for rapid employment across the spectrum of SOF operational requirements. AFSOC medics interface with conventional, nonconventional, joint and coalition medical forces as dictated by circumstances and requirement. AFSOC medical personnel must be interoperable with all other SOF medical personnel. Personnel who are selected for SOFME assignments must be highly motivated, intelligent, adaptable, physically fit and extremely well-trained. AFSOC medics must be trained to perform their roles at night, during low-light or blackout conditions, in environmental extremes and in combat environments.

**7.3.1. Joint Medical Training.** Successful joint interoperability is achieved through joint medical training standards. Special Operations Combat Medic (SOCM) is the current standard (as outlined in USSOCOM Directive 40-2, Medical Service) which all component medics and pararescue personnel use as a baseline.

**7.3.2. Air Force Medical Service (AFMS) Medical Training.** AFSOC medical personnel will train and maintain medical readiness skills, clinical currency, medical licensure and specialty credentials IAW AFI 41-106, *Unit Level Management of Medical Readiness Programs*, AFI 44-119, *Medical Quality Operations*, AFSOCI 48-101, *Special Operations Aerospace Medical Operations* and USSOCOM Directive 350-29, *Special Operations Forces Medical Training*, and other AFSOC guidance. Metric requirements for tracking specific training will be provided by AFSOC/SG.

**7.3.3. AFSOC Medical Training.** The AFSOC medical training program is designed to meet the unique challenges of special operations duty. There is considerable resource investment required to fully train AFSOC medical personnel and then maintain a "mission ready" status. All AFSOC medical personnel will meet all training requirements outlined in AFSOCI 48-101, *Aerospace Medical Operations*. Medical units will track and report training status in accordance with AFI 41-106, AFI 10-201, *Status of Resources and Training System*, and other AFSOC guidance. Metric requirements for tracking specific training line items will be provided by AFSOC/SG.

**7.3.4. UTC-specific Training.** AFSOC medical personnel assigned to deployable UTCs may have additional training requirements in order to provide all capabilities as per MISCAPS as well as to ensure complete familiarity with UTC equipment and supplies. These additional training requirements are outlined in AFSOCI 48-101, *Aerospace Medical Operations*. Medical units will track and report training status in accordance with AFI 41-106, AFI 10-201, and other AFSOC guidance. Metric requirements for tracking specific training line items will be provided by AFSOC/SG.

**7.3.5. Operational Training.** AFSOC medical personnel are expected to operate effectively across a variety of austere, far-forward scenarios as well as in the airborne environment on AFSOC and other opportune SOF aircraft. The requirements for training include advanced survival training, advanced weapons training, night operations training, small unit tactics, aircraft emergency procedures, egress training and use of aircraft emergency equipment. Additionally, AFSOC medical personnel must be trained to meet USSOCOM interoperability requirements.

**7.3.6. Pararescue Forces Guidance.** All pararescue forces will meet the training requirements as outlined in the Pararescue (1T2X1) Career Field Education and Training Plan, AFI 16-1202, *Pararescue Operations, Techniques and Procedures*, AFSOCI 16-1201 and AFSOCI 16-1202. PJ forces will track and report training status in accordance with AFI 10-201, and other AFSOC guidance.

**7.4. Credentials.** AFSOC medical personnel must fulfill all medical credentialing requirements IAW USAF and home station medical group credentialing requirements.

**7.5. Recruitment.** Recruitment of AFSOC medical personnel must take into consideration the nature of the SOF mission. Candidates must be highly motivated; have a proclivity for the mental and physical challenges associated with AFSOC operational medic duties; willingly accept a high operations tempo that has the potential to interfere with personal interests (e.g., family life); be prepared to tolerate environmental extremes and substandard living conditions; accept a level of physical risk greater than that faced by conventional medical forces; function effectively despite circadian disruption; possess the interpersonal skills needed to integrate with SOF. Candidates must also be able to meet rigorous training requirements as delineated in this chapter and AFSOCI 48-101.

## Chapter 8

### COMMUNICATIONS

**8.1. Medical Communications.** AFSOC medical personnel must be able to communicate with other SOFME members via secure intra-team radios, with other tactical SOF elements via secure line-of-sight communications and with SOG, SOW, TSOC, and AFSOC headquarters via secure beyond-line-of-sight communication as well as via secure and non-secure internet access. The key to good communications and connectivity with other elements starts with good pre-deployment mission planning. AFSOC medical personnel should coordinate deployed communications requirements with SOG communications planners. AFSOC medics cannot rely on conventional FOB support for its communications needs and must be prepared to deploy with communications capability.

**8.2. Intra-team communications.** The primary intra-team communications mechanism is the Multi-band Inter/Intra Team Radio (MBITR) system. Additionally, for emergencies, the team should have access to Iridium phones and local cellular phones. Given the frequent requirement to provide medical care at multiple sites while deployed, each AFSOC medic may require a cell phone as well as a MBITR.

**8.3. Line-of-sight communications.** In general, AFSOC medics use the aircraft radios and/or the supported team's radios. However, they may require line-of-sight radios if working independently or with a small team. During CASEVAC missions AFSOC medical personnel must have the capability to communicate with the CASEVAC aircrew from aid stations or medical facilities that are not necessarily adjacent to the runway during CASEVAC missions.

**8.4. Beyond-line-of-sight communications.** Normally, the AFSOC medics use aircraft or the supported team's satellite communications (SATCOM). However, they may require organic SATCOM radios in special situations such as when working independently or with a small team. Standard operating procedure is to maintain SATCOM connectivity with higher headquarters.

**8.5. Internet access.** To maintain planning capacity, the AFSOC medics must have access to Secret Internet Protocol Router Network (SIPRNET) for email and portal access. Due to clinical and preventive medical requirements, they must also have access to Non-secure Internet Protocol Router Network (NIPRNET).

CHARLES B. GREEN  
Lieutenant General, USAF, MC, CFS  
Surgeon General



## **Attachment 1**

### **GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION**

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#### ***Forms***

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#### ***Abbreviations and Acronyms***

ACLS – Advanced Cardiac Life Support  
ACS – Agile Combat Support  
ADVON – advanced echelon  
AE – Aeromedical Evacuation  
AEF – Aerospace Expeditionary Force  
AELT – aeromedical Evacuation Liaison Team  
AFFOR – Air Force Forces  
AFMIC – Armed Forces Medical Intelligence Center  
AFMS – Air Force Medical Service  
AFRC – Air Force Reserve Command  
AFSC – Air Force Specialty Code

AFSOC – Air Force Special Operations Command  
 AFSOD – Air Force Special Operations Detachment  
 AFSOF – Air Force Special Operations Forces  
 AFSOTC – Air Force Special Operations Training Center  
 AFTH – Air Force Theater Hospital  
 AFTTP – Air Force Tactics, Techniques, and Procedures  
 AFTH – Air Force Theater Hospital  
 ALS – Advanced Life Support  
 AMC – Air Mobility Command  
 ANG – Air National Guard  
 AOB – Advance Operating Base  
 AOR – Area of Responsibility  
 ARC – Air Reserve Components  
 ARFOR – Army forces  
 ART – AEF Reporting Tool  
 AS – Allowance Standard  
 ATF – after the fact  
 ATLS – Advanced Trauma Life Support  
 ATTU – Air Transportable Treatment Unit  
 AvFID – Aviation Foreign Internal Defense  
 BAO – Battlefield Air Operations  
 BISC – Biomedical Initiatives Steering Committee  
 BOS – Base Operating Support  
 BW – Biological Warfare  
 C2 – Command and Control  
 CA – Civil Affairs  
 CAA – Combat Aviation Advisor  
 CASEVAC – Casualty Evacuation  
 CCATT – Critical Care Air Transport Team  
 CCT – Combat Control Team  
 CD – counter drug  
 CDRJSOTF – Commander Joint Special Operations Task Force  
 CHOP – Change of Operational Control  
 CJCS – Chairman of the Joint Chiefs of Staff  
 CJSOAC – Combined Joint Special Operations Air Component  
 CJSOTF – Combined Joint Special Operations Task Force  
 CMO – Cooperative Medical Oversight  
 CINC – Commander in Chief  
 COCOM – Component Commander  
 COCOM/SG – Component Commander/Surgeon General  
 COMAFFOR – Commander, Air Force Forces  
 COMUSSOCOM – Commander, United States Special Operations Command  
 CONOPS – Concept of Operations  
 CONUS – Continental United States  
 COP – combat outpost  
 COIN – Counterinsurgency  
 CSAR – Combat Search and Rescue  
 CSH – Combat Support Hospital

CSTARS – Center for Sustainment of Trauma and Readiness Skills  
CT – counter terrorism  
CW – chemical warfare  
CWT – Combat Weather Team  
DA – direct action  
DEPID – Deployment Indicator Code  
DEW – directed energy weapons  
DIA – Defense Intelligence Agency  
DLA – Defense Logistics Agency  
DNBI – Disease Non-Battlefield Injury  
DRRS – Defense Readiness Reporting System  
DOC – Designed Operational Capability  
DOD – Department of Defense  
DODI – Department of Defense Instruction  
DODAC – Department of Defense Acquisition Code  
DRU – direct reporting unit  
DVA – Department of Veteran Affairs  
ECS – Expeditionary Combat Support  
EMEDS/ – Expeditionary Medical Support  
EMT-P – Emergency Medical Technician - Paramedic  
EMS – Expeditionary Medical Support  
EMT – Emergency Medical Technician  
ERO – engines running on/off-loads  
FARP – forward area refueling point  
FB – Fire Base  
FID – Foreign Internal Defense  
FOB – Forward Operating Base  
FSB - Forward Staging Base  
FRS – Forward Resuscitative Surgery  
GCC – Geographic Combatant Commander  
GPC – Government Purchase Card  
GPS – Global Positioning System  
HA – humanitarian assistance  
HAAMS - High Altitude Airdrop Mission Support  
HCA – humanitarian and civic assistance  
HLZ – Helicopter Landing Zone  
HMMWV – High Mobility Multipurpose Wheeled Vehicle  
HMTF – host medical treatment facility  
HN – host nation  
HPE – Human Performance Enhancement  
HPT – Human Performance Team  
HSS – Health Service Support  
IAW – in accordance with  
ICU – Intensive Care Unit  
IDMT – Independent Duty Medical Technician  
IHS – International Health Specialist  
IO – Information Operations  
IOT – in order to

ISB – Intermediate Staging Base  
ISR – Intelligence, Surveillance and Reconnaissance  
ISO – in support of  
ISU – Insulated Slingable Unit  
IW – Irregular Warfare  
IW/MSO – Irregular Warfare/Medical Stability Operations  
JFACC – Joint Force Air Component Commander  
JFC – Joint Force Commander  
JFCOM – Joint Forces Command  
JFSOCC – Joint Force Special Operations Component Commander  
JPRA – Joint Personnel Recovery Agency  
JSOAC – Joint Special Operations Air Component  
JSOACC – Joint Special Operations Air Component Commander  
JSOAC/SG – Joint Special Operations Air Component Surgeon  
JSOC – Joint Special Operations Command  
JSOTF – Joint Special Operations Task Force  
JSOTF/SG – Joint Special Operations Task Force Surgeon General  
JSRR – Joint Survival Recovery Center  
JTF – Joint Task Force  
LAF – Line of the Air Force  
LEP – Laser Eye Protection  
LOC – lines of communication  
LRRC – Loaner Replacement and Repair Center  
MA – Medical Attendants  
MAG – Military Assistance Group  
MAJCOM – Major Command  
MASF – Mobile Aeromedical Staging Facility  
MBITR – Multi-band Inter/Intra Team Radio  
MEDEVAC – Medical Evacuation  
MEMO – Medical Equipment Management Office  
METLs – Mission Essential Task Lists  
MFST – Mobile Field Surgical Team  
MISCAPS – Mission Capabilities Statement  
MISO – Military Information Support and/to Operations  
MMC – Medical Material Centers  
MOB – Main Operating Base  
MOOTW – Military Operations Other than War  
MTF – Medical Treatment Facility  
MRDSS – Medical Readiness Decision Support System  
MSO – Medical Stability Operations  
NEO – Noncombatant Evacuation Operations  
NAVFOR – Navy forces  
NAVAIDS – navigation aids  
NAVSPECWAR – Naval Special Warfare Command  
NBC – nuclear, biological, and chemical  
NCO – noncommissioned officer  
NCMI – National Center for Medical Intelligence  
NEO – noncombatant evacuation operation

NIPRNET – Non-secure Internet Protocol Router Network  
OCONUS – Outside the Continental United States  
OPCON – operational control  
OPR – Office of Primary Responsibility  
OPSEC – operations security  
OSM – operations support medical  
PA – Physician Assistant  
PALS – Pediatric Advance Life Support  
PACAF – Pacific Air Force  
PAR – Population at Risk  
PAX - Passengers  
PHA – Preventive Health Assessment  
PHTLS – Pre Hospital Trauma Life Support  
PJ – Special Tactics Pararescue Specialist  
PJ MOAB – Pararescue Medical Oversight Advisory Board  
PMI – Patient Movement Items  
PMRC – Patient Movement Requirement Center  
PN – Partner Nations  
POL – petroleum, oils, and lubricants  
PR – personnel recovery  
RAM – Resident in Aerospace Medicine  
RDS – Records Disposition Schedule  
RRDK –Rapid Response Deployment Kit  
RTD – Return to Duty  
SA –security assistance  
SABC – Self Aid and Buddy Care  
SAM – Specialized Air Mobility  
SATCOM – Satellite Communications  
SEAL – sea-air-land  
SecDef – Secretary of Defense  
SERE – Survive Evade Resist Escape  
SF – Special Forces  
SG – Surgeon General  
SIMLM – Single Integrated Medical Logistic Manager  
SIPRNET – Secret Internet Protocol Router Network  
SME – Squadron Medical Element  
SMO – Senior Medical Officer  
SO – special operations  
SOCAFRICA – Special Operations Command Africa  
SOCCENT – Special Operations Command Central  
SOCCET – Special Operations Critical Care Evacuation Team  
SOCEUR – Special Operations Command Europe  
SOCJFCOM – Special Operations Command Joint Forces Command  
SOCKOR – Special Operations Command Korea  
SOCM – Special Operations Combat Medic  
SOCPAC – Special Operations Command Pacific  
SOCSOUTH – Special Operations Command South

SOF – special operations forces  
 SOFME – Special Operations Forces Medical Element  
 SOG – Special Operations Group  
 SOMDG – Special Operations Medical Group  
 SORTS – Status of Resources and Training System  
 SOSS – Special Operations Support Squadron  
 SOST – Special Operations Surgical Team  
 SOTF – Special Operations Task Force  
 SOW – Special Operations Wing  
 SR – special reconnaissance  
 SREF – Specialized Refueling  
 STG – Special Tactics Group  
 STT – Special Tactics Team  
 STS – Special Tactics Squadron  
 TACCOM – Tactical Communications  
 TACON – Tactical Control  
 TCAM - TAMMIS Module TCAM stands for Theater Army Medical Management Information System (TAMMIS) Customer Assistance Module  
 TACP – Tactical Air Control Party  
 TLAMM – Theater Lead Agent for Medical Material  
 TSOC/SG – Theater Special Operations/Command Surgeon  
 TSG – theater surgeon  
 TSOC – Theater Special Operations Command  
 TTP – tactics, techniques, and procedures  
 UCAM - USAMMCE Customer Assistance Module  
 UK – United Kingdom  
 USAMMCE – United States Army Medical Materiel Center Europe  
 USA – United States Army  
 USAF – United States Air Force  
 USAFSOS – United States Air Force Special Operations School  
 USCENTCOM – United States Central Command  
 USCG – United States Coast Guard  
 USEUCOM – United States European Command  
 USMC – United States Marine Corps  
 USN – United States Navy  
 USNORTHCOM – United States Northern Command  
 USASOC – United States Army Special Operations Command  
 USFK – United States Forces Korea  
 USSOCOM/CC – United States Special Operations Command Commander  
 USSOCOM – United States Special Operations Command  
 USSOUTHCOM – United States Southern Command  
 UTC - Unit Type Code  
 UW – Unconventional Warfare  
 WMD – weapons of mass destruction  
 WRM – War Reserve Materiel

## *Terms*

Aeromedical Evacuation (AE) specifically refers to United States Air Force (USAF) fixed wing movement of regulated casualties, using organic and/or contracted mobility airframes, with AE aircrew trained explicitly for this mission. (JP 4-02 and JP 3-17)

casualty evacuation (CASEVAC) – The unregulated movement of casualties that can include movement both to and between medical treatment facilities. (JP 4-02) Movement of patients using any vehicle of opportunity (to include fixed wing assets) from either the point of injury and/or a transload site to a higher level of medical care or a regulated patient movement system.

Damage control surgical stabilization – Surgery that is required to save life or limb and to stabilize a patient for transport.

medical evacuation (MEDEVAC) – A term used to delineate the use of dedicated platforms to carry patients which are designed for the express purpose of providing en route care. Medical evacuation (MEDEVAC) traditionally refers to US Army (USA), US Navy (USN), US Marine Corps (USMC), or US Coast Guard (USCG) patient movement using pre-designated tactical or logistic aircraft, boats, ships, and other watercraft temporarily equipped and staffed with medical attendants (MA) for en route care.

patient movement items (PMI) – PMI consists of designated medical equipment, durable supplies, and consumable supplies necessary to support a patient during aeromedical evacuation

pararescue team – Specially trained personnel qualified to penetrate to the site of an incident by air, land or sea, render medical aid, accomplish survival methods and rescue survivors. (JP 1-02)

special operations — Operations conducted in hostile, denied, or politically sensitive environments to achieve military, diplomatic, informational, and/or economic objectives employing military capabilities for which there is no broad conventional force requirement. These operations often require covert, clandestine, or low visibility capabilities. Special operations are applicable across the range of military operations. They can be conducted independently or in conjunction with operations of conventional forces or other government agencies and may include operations through, with, or by indigenous or surrogate forces. Special operations differ from conventional operations in degree of physical and political risk, operational techniques, mode of employment, independence from friendly support, and dependence on detailed operational intelligence and indigenous assets. Also called SO. (JP 3-05)

special operations forces – Those Active and Reserve Component forces of the Military Services designated by the Secretary of Defense and specifically organized, trained and equipped to conduct and support special operations. Also called SOF. (JP 1-02)

special tactics — US Air Force special operations forces organized, trained, and equipped to conduct special operations. They include combat control team, pararescue, and combat weather personnel who provide the interface between air and ground combat operations. Also called ST. See also special tactics team (STT). (JP 1-02)

special tactics team — A task-organized element of special tactics that may include combat control, pararescue, and combat weather personnel. Functions include austere airfield and assault zone reconnaissance, surveillance, establishment, and terminal control; terminal attack control; combat search and rescue; combat casualty care and evacuation staging; and tactical weather observations and forecasting. Also called STT. (JP 1-02)

stabilized patient — A patient whose airway is secured, hemorrhage is controlled, shock treated, and fractures are immobilized. (JP 4-02.2)

transload – Transfer of casualties from one form of conveyance to another. Examples would be using an MC-130 or SF ground vehicle to CV-22, to facilitate casualty evacuation from forward areas. A transload also implies that casualty care is transferred from one team to another. This function can be performed across the spectrum of permissive, denied or hostile environments.



## **Attachment 2**

### **AFSOC AE PLANNING REQUIREMENTS**

**A4.1.** Although AFSOC does possess organic CASEVAC capability, AFSOC does not possess organic conventional AE capability. Therefore SOFME personnel and medical planners must identify AE requirements and obtain conventional AE support when required. As the USSOCOM air component surgeon, AFSOC/SG has the overall responsibility for identifying and coordinating SOF AE requirements. TSOC medical planners have the responsibility for identifying AE requirements in theater plans. SOG medical planners should coordinate AE requirements with TSOC and geographic conventional air component planners. Deliberate planning should include the movement of SOF patients from forward or remote areas back to military or HN medical treatment facilities that have the capabilities to provide the appropriate level and standard of care. Additionally, deliberate planning should address the SOF medical interface with the conventional theater and inter-theater AE system for patient movement requirements.

**A4.2.** SOFME CASEVAC and conventional AE integration must be considered during the planning process. Deliberate and crisis action planning match SOF missions to SOF casualty evacuation and conventional AE capabilities. SOF missions require a flexible response. Therefore, conventional AE units tasked to support SOF missions may occasionally be required to modify or adjust their operational concepts to meet SOF mission requirements. An AE planner may be an active participant in the SOF mission planning process when AE support may be required. The JSOAC surgeon and medical planner will develop and coordinate all JSOAC medical support requirements with TSOC and conventional AE planners. Conventional AE units need not obtain SOF-type equipment.

**A4.3.** Doctrinal SOF and AE differences will be addressed in the planning process. SOF does not utilize patient movement items (PMI) and provides limited casualty documentation. However, predetermined PMI may need to be placed at forward or intermediate staging bases. Little or no medications will accompany SOF patients. Medical regulation of patients from SOF mission locations or FOBs does not occur. Instead, patients may be moved to pre-designated theater MTFs. SOF medical equipment is limited and may not move with the patient. AE UTCs may require significant pairing and tailoring to support SOF missions. The concept of operations may be fluid until the time of mission execution with frequent adjustments.

**A4.4.** During a major contingency, interface with conventional AE may occur at either an FSB or ISB, depending on the scenario. In a SOF-only operation (or exercise), conventional AE may not be available. In these instances, the SOFME has three options: 1) hold the casualty at the deployed location and wait for conventional AE; 2) use HN medical support; or 3) continue transport via SOF opportune aircraft to a location where a link with the conventional AE system is available. The option chosen will depend on the condition of the casualty as well as the availability of both SOF and conventional AE aircraft for casualty transport.